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**LINCOLN-DOUGLAS** | November/December 2012

**Resolved: The United States ought to guarantee universal health care for its citizens.**

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## Topic Analysis by Larry McGrath

On its face, healthcare seems to be a desirable good. There's little risk in contending that healthcare is a basic enough provision that most people living in advanced societies at least deserve access to it. Moreover, the resolution suffers (or perhaps enjoys) a certain reality-check bias. Most liberal-minded folks who go to the ballot boxes in November believe that everyone, regardless of their status, should have a right to healthcare. Even libertarians find the thought of denying healthcare to someone who, for extraneous reasons, cannot access healthcare odious. Liberals and conservatives argue over *who* should provide healthcare: the state, the market, or both. They rarely spar over *whether* healthcare should be provided. In this topic analysis I would push the topic to its limits and broach the possibility of questioning this assumption.

Consider the following scenario.

A woman gives birth to a baby weighing 615 grams. It is premature, born 23 weeks into the mother's pregnancy. The baby, its lungs not fully developed, is unable to breathe on its own. Doctors intervene immediately. They resuscitate the baby and proceed to attach it to a ventilator, part of the many medical technologies that allow it live by artificial means. The mother, however, protests. She knows that the child already suffers from birth defects and they will only amplify over time. The baby, although loved by her mother, will endure a bed-ridden life, perhaps never able to develop cognitive skills.

The doctors thwart the mother's wishes and pursue the rescue unabated. Equipped with the most advanced neonatal technology, their duty is to ensure the child's life at whatever cost. And they are successful. The child continues to live, although unable to enjoy the life of a normal human that most of us take for granted. Now a teenager, she has cerebral palsy, cannot walk or talk, and is incontinent. The costs incurred to the parents are overwhelming: the special attention the child requires is, of course, monetarily draining; but the parents are also racked with guilt for having brought a child into the world who only knows suffering. They regret having allowed the doctors to insist on guaranteeing the baby's health.

The scenario is real: it is the case of Miller vs. HLC. The Millers sued the Houston hospital for having refused their wish to deny their baby, Sidney, healthcare. In 1998 a jury awarded the Millers compensatory damages equal to what it would cost to care for Sidney until the age of 70. But when the case made its way to the Texas Supreme Court in 2002, the justices ruled that that hospital had not violated the Millers' decision-making authority. Although doctors usually rely on parents' consent before providing life-sustaining treatment, "emergent circumstances," the court



held, permit the hospital to bypass the parents. Sidney's critical condition did not leave enough time to formally consult the parents – despite their vocal objections. Faced with imminent death, doctors are required to do all they can to guarantee the baby's life.

The Millers' case, albeit extreme, is not entirely fantastic. 450,000 babies are born before the full 39-week gestation period each year in the United States. Whether they are born early for spontaneous or provider-induced reasons, the scenario throws the desirability of healthcare into stark relief. Even extremely premature babies, after all, are officially citizens at the moment of birth. Their context illuminates just how undesirable it would be for the state not simply to *offer* healthcare – in which case the parents' consent would be solicited – but more gravely, to *guarantee* healthcare – in which case the parents' consent is overridden.

The thought of forcing someone to live a life of suffering is of course undesirable. Yet the acutely reality, moreover, is that premature babies confront the undesirable situation of finding themselves, as one family reports, "hopelessly entrapped in an intensive care unit where the machinery is more sophisticated than the code of law and ethics governing its use."<sup>1</sup> Here the Millers' case reveals the disparity between the two. The law entrusts doctors with the duty to ensure a baby's life because the ethical problem proves too complicated. As the justices affirmed:

"The emergent circumstances exception acknowledges that the harm from failing to treat outweighs any harm threatened by the proposed medical treatment, because the harm from failing to provide life-sustaining treatment under emergent circumstances is death. And it is impossible for the courts to calculate the relative benefits of an impaired life versus no life at all."<sup>2</sup>

The last line is critical: it marks the point where debates this November and December, I am suggesting, take their point of departure. The court recognized that weighing the benefits of a poor life to no life at all poses too thorny a problem. An exclusively legal paradigm drove the court to instead resolve the problem by using, as it were, a body-count standard. Citizens, all equal before the law, have the same right to life. According to this understanding of life, doctors must guarantee healthcare for the baby at any cost, since death – in both the debate world and the legal world – is the terminal impact.

Yet, there is genuinely ethical problem concerning the quality of life that remains. Although death might be the terminal impact, it is also the least satisfying impact. Indeed, it seems to be a cop-

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<sup>1</sup> Robert & Peggy Stinson, "On the Death of a Baby," *Journal of Medical Ethics* 7, no. 5 (1981), 5.

<sup>2</sup> "Miller v. HCA," Supreme Court of Texas, NO. 01-0079 (2002). Citation: 118 S.W.3d 758; 2003 Tex. LEXIS 410; 47 Tex. Sup. J. 12

out: a punt in the face of a vexing ethical problem. It belies is the sobering position that Sidney's life is worse than no life at all. The ethical principle may be straightforwardly put as follows:

Nuffield Council on Bioethics, "Critical care decisions in fetal and neonatal medicine: ethical issues." 2006, page accessed online: <[www.nuffieldbioethics.org](http://www.nuffieldbioethics.org)>

For some babies, whose quality of life is what we would describe as 'intolerable', an insistence that their lives must always be preserved, regardless of suffering, is inhumane and of no possible benefit to them.

Confronted with the question of whether the doctors should have guaranteed Sidney's life, we have ourselves a good ole' fashioned value debate: the sanctity of life confronts the quality of life. What the particular case of premature babies demonstrates for health care generally is that questions of *health* are not easily reducible of questions of *life*. Although an affirmative world in which Sidney is alive garners an impact to a body-count standard, a competing negative world in which the state does not guarantee her healthcare would garner an impact to a quality of life standard. Guaranteeing Sidney's life would desecrate its quality. Call me a dinosaur for believing that values are still relevant to LD debate. It is clear nonetheless that the dispute can only be resolved at the standards level.

Freedom is typically understood, certainly in debate at least, in positive terms. Freedom is desirable because it protects a person's pursuit of the good life, the right to self-actualization, and free expression. When considered under the legal paradigm presupposed in most debate rounds, and employed by the Texas Supreme court, this positive sense of freedom is easily quantifiable: more people alive means more people who can flourish as they please. It could even be said that the legal paradigm is embedded in the resolution's language of "citizens." Citizenship is a fungible category. There are more citizens with immigration, for example, fewer with emigration. And rights are treated in the same way. All that matters from the perspective of the legal paradigm is which rights can be predicated of citizens. There is little care for who a particular citizen is – his background, circumstances, or promise. What matters is that he *has* them. It is precisely because the picture of the rights-bearing citizen is so hollow that it is so easily quantifiable. Abandoning questions of legal right in favor of questions of bioethics shifts the purview of the resolution to issues not easily resolvable under a body-count standard. This is because it encourages debaters to instead consider liberty in qualitative terms, which involves entertaining the negative sense in which liberty is valuable.

At stake is whether the right to incur harm to oneself is part of the good life. Should people undergo pain, even death, for the sake of avoiding a diminished quality of life? The answer implicates any conception of health on which the guarantee of healthcare turns. In this light, Sidney's story engages ethical stakes often reserved for rarified cases like euthanasia. Actively terminating a terminally ill life is certainly different than passively allowing a premature baby to die. What is evidently similar, however, is the conflict that both cases raise between the sanctity and quality of life, and with it, the respective conceptions of liberty as quantitative and qualitative. A quantitative conception of the sanctity of life, when run as a standard, would eliminate the possibility of including either in the packages of services included in a healthcare regime. Defenders of the sanctity of life do not likely see their understanding of life in quantitative terms; yet insofar as sanctity is ensured by the *fact* of being alive, it lends itself to measurement on a balance sheet. Ensuring the quality of life hinges on how life is *experienced* in non-numerical terms.

The fact that these two bioethical cases – neonatal care and doctor-assisted suicide – subtend life at its beginning and end betrays the deeper reality that the qualitative issues they offer up for debate are at play throughout life. Avoiding a diminished quality of life, in other words, need not come at the price of death. Taking illicit drugs, getting a tattoo, even hiking the Appalachian Trail, for example, may potentially be harmful. If a qualitative conception of freedom includes the right to incur harm, then all would be permissible activities under a health care regime. By contrast, a quantitative conception of freedom – one that treats the potential for harm in each as decisive – would omit them from the list of permissible activities. What activities the state decides to single out as legitimate health risks depends on the type of standard a debater chooses to run.

My comments point toward the value-laden nature of healthcare. It does not denote a given package of goods. "Health" is a slippery notion: culturally specific, politically charged, and relative to an individual's desires. The German philosopher Friedrich Nietzsche made this point forcefully when he wrote:

Friedrich Nietzsche [Nineteenth-Century German philosopher]. *The Gay Science*, trans. Walter Kauffman. 1974, originally published 1882, 176-177.

The popular medical formulation of morality that goes back to Ariston of Chios, "virtue is the health of the soul," would have to be changed to become useful, at least to read: "*your* virtue is the health of *your* soul." For there is no health as such, and all attempts to define a thing that way have been wretched failures. Even the determination of what is healthy for your *body* depends on your goal, your horizon, your energies, your impulses, your errors, and above all on the ideals

and phantasms of your soul. Thus there are innumerable healths of the body; and the more we allow the unique and incomparable to raise its head again, and the more we abjure the dogma of the "equality of men," the more must the concept of a *normal* health, along with a normal diet and the normal course of an illness, be abandoned by medical men. Only then would the time have come to reflect on the health and illness of the *soul*, and to find the peculiar virtue of each man in the health of his soul. In one person, of course, this health could look like its opposite in another person.

Finally, the great question would still remain whether we can really dispense with illness—even for the sake of our virtue—and whether our thirst for knowledge and self-knowledge in particular does not require the sick soul as much as the healthy, and whether, in brief, the will to health alone, is not a prejudice, cowardice, and perhaps a bit of very subtle barbarism and backwardness.

Nietzsche should not be read to support the claim that health is merely a relative notion. His stronger claim is rather that sickness has the potential be productive, and moreover, that treating each bout of sickness as something to remedy can, paradoxically, be unhealthy. During his late years spent in convalescence, Nietzsche reflected on his insanity, "being sick can even become an energetic *stimulus* for life, for living *more*."<sup>3</sup> One is left to wonder whether the *quality* of Nietzsche's literature would have diminished were he not sick. And the same can be said for countless brilliant minds who endure maladies: the mathematician John Nash is an exemplar case, popularized by the film *A Beautiful Mind*, and there are other notable schizophrenics like the jazz trumpeter Tom Harrell and the artist Vincent Van Gough.

That there is health is sickness (and, ask hypochondriacs, sickness in health) reveals that guaranteeing healthcare entrenches norms as to what constitutes a healthy human. Psychological health is the most glaring case. The question of what makes a mind healthy, and, more importantly, what clinical psychiatric methods deserve state support, are both replete with political ramifications. For example, it was only in 2008 that Congress passed a mental health parity law requiring insurers to cover treatment for anorexia-nervosa patients. Most insurers still do not cover psychoanalysis, with little hope in sight for state funding.

Much can be made of psychological cases, but somatic ones are also not neutral. Drug use and abuse might seem to stray too far from the standard provisions of a public healthcare regime. But it is important to consider the residual effects on governmental policy that a guarantee to healthcare might cause. Law professor Deborah Stone argues that state-funded health care tends to generate greater demand for health services. Stone builds her argument on the idea of

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<sup>3</sup> Friedrich Nietzsche, *Ecce Homo*, trans. Walter Kaufmann (New York: Vintage, 1967), 224.

moral hazard, which holds that people take greater risks when they do not occur the costs. She extrapolates the idea to a political principle, arguing, “through its effects on political culture and collective political action, insurance increases the number and kinds of events that we consider adverse and worthy of collective responsibility. Thus, insurance has an inherent expansionary dynamic: insurance tends to beget more insurance.”<sup>4</sup> Stone’s article is worth reading for the sake of considering how guaranteeing healthcare might guarantee other provisions that, at first blush, fall outside its immediate domain. She ultimately argues that the expansionary effect is beneficial: public healthcare creates markets for services and promotes expectations that they be made available. But her logic can be used to highlight other deleterious effects. Unhealthy activities come to be perceived as threatening the community, and not just the individual, once healthcare becomes a public affair. New Yorkers no longer allowed to consume large beverages on account of the public obesity risk is a case in point.

Stone’s argument that healthcare policy affects other areas situates healthcare along a spectrum of overlapping goods. In fact, the notion of healthcare as a discrete good that states and corporations provide emerged relatively recently. According to the historian Michel Foucault, the modern notion of healthcare reflects an effort to isolate sickness as one problem among many confronting poor people. Prior to the eighteenth century, “medicine understood and practiced as a “service” operated simply as one of the components of “assistance.” It was addressed to the category, so important despite the vagueness of its boundaries, of the “sick poor.” In economic terms, this medical service was provided mainly thanks to charitable foundations. Institutionally it was exercised within the framework of lay and religious organizations devoted to a number of ends: distribution of food and clothing, care for abandoned children, projects of elementary education and moral proselytism, provision of workshops and workrooms, and in some cases the surveillance of “unstable” or “troublesome” elements.”<sup>5</sup> There is an intuitive appeal to the pre-modern context of health, which, when used to as a vantage point from which to survey the present, makes the modern context of healthcare appear strange. There was nothing special about health. Health was simply one thing among a host of others that poor people lacked. Health was a concern of daily affairs that bled seamlessly into other concerns. “Sickness is only one among a range of factors – including infirmity, old age, inability to find work, and destitution – that compose the figure of the “needy pauper” who deserves hospitalization.”<sup>6</sup>

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<sup>4</sup> Deborah Stone, “Conference Article: Beyond Moral Hazard: Insurance As Moral Opportunity,” *Connecticut Insurance Law Journal Association*, no. 6 (1999), page accessed online: <6 Conn. Ins. L.J. 11>

<sup>5</sup> Michel Foucault, “The Politics of Health in the Eighteenth Century,” *Power. Essential Works of Michel Foucault*, Vol. 3, trans. Robert Hurley (New York: The New Press, 2000), 92.

<sup>6</sup> Ibid. 93

Isolating health as particular category and solidifying healthcare as a particular good reflects a movement set underway in the eighteenth century that aimed to measure the health of the entire society. “[T]his is the emergence,” Foucault continues, “of the health and physical well-being of the population in general as one of the essential objectives of political power. Here it is not a matter of offering support to a particularly fragile, troubled, and troublesome margin of the population but of how to raise the level of health of the social body as a whole. Different power apparatuses are called upon to take charge of “bodies,” not simply so as to exact blood service from them or levy duties but to help and if necessary constrain them to ensure their own good health. The imperative of health – at once the duty of each and the objective of all.”<sup>7</sup>

Foucault’s point is that the modern notion of healthcare serves to consolidate norms as to what constitutes a properly healthy body, and moreover, to make those norms consistent across a population. It is worth noting that there is nothing inherently wrong with this. I am thankful that physicians have standardized health manuals that include uniform treatment guidelines. The value of Foucault’s insight is that it helps debaters make sense of the mechanism by which healthcare encodes certain conceptions of health and excludes others. Once health is enshrined as a public good, it becomes a domain to police. The state puts itself in a position not only to provide health services, but also to deem which services are not worth providing. Healthcare, in other words, is a malleable instrument easily pressed into the service of political objectives. These are qualitative questions that a body-count standard proves too clumsy to handle.

Foucault’s insight can be examined in light of recent efforts to protect the health of fetuses. I opened by examining babies who are citizens. I would like to conclude by considering unborn babies who are on the brink of citizenship. A growing reactionary movement in America has taken aim at pregnant mothers who take drugs because, so the argument goes, they jeopardize the “life” of the fetus. Whether or not fetuses are in fact *living* beings, it is fair to say that drug use during pregnancy does threaten their potential life. The push to construe unborn children as alive undergirds legal efforts to prosecute drug-using mothers for child abuse. A spate of such litigation flared during the 1990s. And in the last decade, the incidence of prosecutions has grown rampantly.

“Fetal Abuse,” *Mother Jones*. June 14, 2000, page accessed online:

<<http://www.motherjones.com/politics/2000/06/fetal-abuse>>

In April, a 26-year-old Texas woman was indicted for child endangerment after her newborn tested positive for cocaine. The same month, a Pennsylvania judge ruled that prosecutors could

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<sup>7</sup> Ibid. 94

charge an addicted mother with child endangerment for using heroin while pregnant -- even if her baby was born healthy. This spring, the Oklahoma state legislature nearly passed a bill making it a misdemeanor for pregnant drug abusers to fail to get substance-abuse treatment. And in Georgia, 21-year-old Shannon Moss is facing murder charges for allegedly killing her fetus by taking cocaine and amphetamines while pregnant.

Protecting fetuses from battery is not tantamount to providing them with healthcare. What brings that scenario closer to reality is the same movements' decision in the past decade to shift their efforts toward recognizing fetuses as citizens. Fetal personhood legislation has gained support in states such as North Dakota, Virginia, and Colorado. Just last year, Mississippi voters considered Initiative 26, which would declare a fetus a legal person and *ipso facto* a citizen. The proposed amendment failed (much to the chagrin of twenty year olds hoping to legally drink nine months early). A world in which fetuses are citizens and the government guarantees healthcare is one of near limitless healthcare expansion. The potential topic literature in tantalizing: Imagine if the state were to guarantee healthcare to unborn citizens. Under a quantitative standard of liberty, the gains are immediate: more living citizens. Under a qualitative standard, the invasive measures necessary to provide healthcare to citizens residing in the womb are, at best, grim.

The fact that this topic will be debated in November heightens the stakes. Should Mitt Romney win the presidential election, cultural conservatives would surely feel emboldened. Their persistent initiatives to put in place fetal personhood amendments would suddenly become both less fanciful and less laughable. Were unborn children to be deemed citizens, and receive healthcare benefits therewith, a scenario that until now seems exceptional, even extreme, could shift to the center of legitimate topic ground.

I hope to have by now opened the possibility of understanding healthcare itself as undesirable. I do not mean to claim that healthcare as such is necessarily bad. I only want to suggest that it is not innocent. My effort to push the resolution to its extremes has lead me to move beyond the question of who provides healthcare. That entails confronting the apparent reality-check coded into the resolution (and getting over the fact that most governments of industrialized societies guarantee healthcare, except for America). I encourage debaters to examine cases that at first appear marginal. That is the only way to unearth the bed of assumptions that quickly sediment as the debate year wears on.

## Topic Analysis by Christian Tarsney

I'm happy with this topic, because it has a feature that typifies nearly all the best LD resolutions I've debated and coached: a relatively even balance of philosophical and empirical ground on both sides. To put this a little more precisely, some ethical theories (e.g. right-libertarian and Rawlsian-egalitarian theories of justice) nearly answer the question of the resolution outright, without much to be said at the contention level, while others (e.g. consequentialist, contractarian, communitarian) interestingly constrain the space for arguments, but still leave significant empirical questions open which give plenty of topical ground for both affirmatives and negatives.

We'll proceed by first addressing issues of textual interpretation and burdens, then examine the general contours of affirmative and negative ground. The sections on affirmative and negative positions will be organized by normative framework, partly to make it easier for you to think in terms of argument interactions within and between moral theories, and partly because I don't have a lot to say about particular topical advantages or disadvantages, which you'll discover in the course of doing research.

### Framework

First, of course, there are the typical debates to be had about "ought," about which little needs to be said. The affirmative is slightly better off interpreting "ought" as indicating "desirability" than "moral obligation," the negative the reverse, but I don't think this does much more than control whether moral skepticism directly negates (if skepticism is true, there are presumably no moral obligations, but it's not hard to imagine salvaging a notion of "desirability" and having substantive disagreements about what policies are desirable). No doubt someone has already cooked up a position that defends on an obviously context-inappropriate definition of "ought" as indicating likelihood, natural expectation, logical consequence, etc., but I'll assume that we're all good enough intuitive semanticists to realize that those definitions don't fit, and that we can therefore ignore the range of positions that rely on them.

A more important framework question concerns what it means to "guarantee universal health care." It makes sense to consider this phrase holistically, rather than trying to think about "guarantee" and "universal health care" separately, because most of the issues with "guarantee" are, in context, really issues about what would count as a universal health care system. A variety of topicality debates are likely to crop up here, so it's worth thinking about all the dimensions on which definitions might vary.



A paradigmatic way of “guaranteeing universal health care” is a single-payer system under which the state covers all costs for the full range of ordinary, health-preserving medical services. From here, we can branch out in a number of directions, and we very quickly run into potential topical gray areas. For instance, what if a universal government insurance scheme charges deductibles and/or copays as a cost control measure? Is it still guaranteeing universal health care? If the fees are high enough that some people can’t pay them, then presumably not. But any fee is conceivably too high for *somebody* to pay, so does *any* cost to the consumer mean that health care has not been universally guaranteed? If so, what about costs that even the most extensive single-payer systems don’t cover, e.g. the cost of getting to and from the hospital or doctor’s office (perhaps also the cost of missed work, or the opportunity cost of missed time)? Which cost barriers could still exist in a world of universal health care and which could not? I don’t propose any definite answers to these questions, but you should be prepared to defend whatever interpretation you adopt.

An especially salient case in point for these topicality questions is Obamacare. I should admit upfront that I don’t know all that much about the details of the legislation, so take what I say with a grain of salt, but in general the idea of the Affordable Care Act is to get everybody (or nearly everybody) covered by insurance via a combination of subsidies (for those who can’t afford it), penalties (to encourage those in good health to buy into the risk pool and drive down costs), and regulation (to prevent insurers from dropping existing policyholders or refusing to take on new ones). All told, the result should be that private health insurance (and, ideally, health *care*) is universally affordable.

But of course “affordable” is a concept with fuzzy boundaries. Policyholders (or their employers) still have to pay a premium for their insurance, presumably (at least in many cases) more than it would have cost to opt out and pay the penalty associated with the individual mandate. And even for those inside the scheme, there are still deductibles and copays which could present financial obstacles to receiving care. So, does Obamacare “guarantee universal health care”? My intuition is that it doesn’t (i.e., that it’s negative ground), but it’s certainly a debate to be prepared for.

Forging back a step in the direction of universal health care, we could consider public-option systems in which the government sells a subsidized or otherwise cost-controlled insurance plan which competes with those offered by private insurers. By driving down insurance costs (a public option would presumably undercut its private competitors, at least for a fairly wide range of potential customers), a public option might make an insurance system (with premiums,

deductibles, and copays) more easily affordable, so even if Obamacare is not affirmative ground, Obamacare-plus-public option might be.

Assuming that a universal health care system must make some basic class of health services affordable to everyone (under some interpretation of “affordable”), there’s also the question of which health services those have to be. Presumably, just providing one vaccine free of charge to everyone in a country would not count as “universal health care,” but also presumably, any universal health care system would decline to cover *some* health-related services (even excluding things like cosmetic surgery). There are more plausibly health-enhancing things we can do for a given individual than we could reasonably provide free of charge (or at an easily affordable charge) to everyone.

Let’s assume, then, that a universal health care scheme would look something like an ordinary insurance policy in terms of the breadth of its coverage—people would have access to primary care, certain preventative services, and a standard range of treatments for any form of illness or injury. Sometimes you’ll see people talk about a “two-tiered” system in which the government (as a single payer, or through insurance subsidies) would cover this range of services while allowing individuals to purchase supplemental insurance policies to cover additional services on a fully private insurance market. This is affirmative ground, given an appropriately specified lower tier, but I can’t see that it does much more than spike out of some unlikely and un-compelling negatives.

One final framework issue: Does “...for its citizens” mean “...*only* for its citizens”? Some negatives will advance this reading in order to set up a range of positions from the jejune (cosmopolitanism) to the barely coherent (“borders” kritiks). But I think that, pretty clearly, it does not. There might be a sort of implicature to that effect (i.e., if I say “Canada provides universal health care for its citizens,” you can reasonably imagine that I mean only its citizens, since if it covered a wider range of people, I as a polite co-conversant would have said so), but this implicature is defeasible (i.e., I could say without contradiction that “Canada provides universal health care for its citizens, but also for some non-citizen residents.”). Therefore, even though the affirmative can’t fiat a broader policy (for reasons of extra-topicality), they can perm any counterplan or alternative that involves extending health care coverage to non-citizens—nothing about the affirmative world *rules out* the possibility of public health care for non-citizens.

## **Affirming**

### *1. Consequentialist arguments*

There's a wide range of consequentialist offense available to affirmatives. For the sake of economy, though, I'm just going to lay out the structure of some core affirmative ground and let you devise potential positions from within (or without) that structure. As far as I can see, there are two basic links which affirmatives can most easily exploit to generate impact scenarios: health outcomes and cost. Each of these are potential consequentialist advantages in their own right, and they will serve as terminal impacts for most stock ACs, but they can also be the links into larger impact scenarios if you so desire.

Arguments about health outcomes are the most obvious areas of ground on the topic, for both affirmatives and negatives. Why might universal health care make people healthier? Here are a few possible reasons:

- In a private market, some people can't afford health care services they need. In a universal health care system, those services are free or at least highly affordable.
- In a private market, even people who *can* afford health care services may underutilize them (because they discount their future health status relative to their present financial status). A universal health care system can solve this kind of irrational behavior by removing the disincentives which might prevent consumers from seeking out care in a timely manner, and making efficient use of preventative services.
- A universal health care system gives the government leverage to efficiently incentivize providers to provide the highest-quality services (and drug companies to point their research efforts in socially optimal directions).
- A universal health care system saves money (see below), and the money saved can be put back into improving quality of care.

No doubt there are additional arguments one could give. From these links you can generate an impact by just reading cards about the number of people who die, preventably, from lack of quality health care in a private system, and claim to solve some part of that. But you can also extrapolate links to larger, generic impact scenarios, e.g. the long-term strength of the economy, military readiness, hegemony, etc.

Then there are cost arguments. There are at least two reasons to think that a universal health care system might save money compared to the alternatives:

- The size of the federal government as a player in the health care market, in either a single-payer or public-option system, gives it enormous leverage to negotiate prices with hospitals, doctors, and drug companies.
- A government payer can cut down on the overhead expenses which insurance companies bear in order to minimize what they pay out in claims. Because they have financial incentives to deny claims when possible (as well as to limit the number of claims that get made), and doing so requires an enormous bureaucratic infrastructure of claims assessors and legal staff, and because this system externalizes further costs onto doctors and hospitals (in particular, the surprisingly enormous cost of medical coding), private insurers do not realize the efficiency gains ordinarily associated with private markets.

Again, this argument can be extrapolated into a variety of impacts. Most of these scenarios will presumably go either through health outcomes (less cost-efficient system provides less valuable services for the same financial input) or through economy (e.g. debt scenarios). There are also, of course, consequentialist impacts of a less body-count-y nature to be had: when people have to spend less of their money on health care, they have more money to spend on other things that (hopefully) contribute positively to their wellbeing.

Some affirmatives will make arguments of this nature directly, without linking through systemic cost savings, but absent systemic saving arguments, there has to be some other explanation of how *individuals* save money on balance in a universal health care system (i.e., how they'll manage to pay less in taxes to support a universal system than they were paying for health care services in the first place). Apart from some unlikely Keynesian arguments, the most likely way of giving that explanation will be through a defense of universal health care as a form of egalitarian redistribution, which leads neatly into our next category of arguments.

## *2. Egalitarian arguments*

The range of positions which could broadly be described as “egalitarian” runs from forms of weighted consequentialism (e.g., so-called “prioritarians” who argue that the welfare of the least

well off should receive preferential weighting in calculations of social utility), through Rawlsian and other contractualist theories of justice which afford the least well off some infeasible (or nearly infeasible) claim to the best standard of living they can be provided, to views like Marxism which (in at least some manifestations) see equality as a social good to be pursued for its own sake.

Given any of these views, policies which serve the interests of the least well off (generally understood in economic terms) are to be preferred. And of course the benefits of a universal health care system accrue most of all to the poor: most obviously, they can access medical services, but secondarily their improved health makes it easier for them to maintain stable employment or pursue an education with the goal of improving their economic status; portable (single-payer or public-option) health coverage makes it easier to change jobs and hence increases social and geographic mobility; and minimal to non-existent medical expenses serve to eliminate the risk of medical bankruptcies.

The contention-level arguments for these positions are fairly straightforward, and shouldn't be too hard to win, so the challenge is to find a framework you like and develop it in a way that will let you clearly exclude the brute-force links negatives will try to generate from their impact scenarios ("nuke war is the greatest harm to the least well off"). For an interesting version of the Marxist egalitarian framework can do this job relatively well, I'd suggest looking at the work of G.A. Cohen.

### *3. Communitarian arguments*

What distinguishes communitarian concerns, generally, is their focus on irreducibly social interests—social interests which are not merely an aggregation of individual interests. I don't know how common communitarian affirmatives will be on this topic, but they're certainly conceivable. Guaranteeing universal health care might be good for communities in a number of ways:

- The burden of disease is partly borne by the social fabric itself. Death, disability, and work absence as a result of disease all weaken the networks of economic and personal relationships on which communities depend.
- Differential access to health care creates resentment, and undermines identification between members of the same political communities. If nothing else, a universal health care system is expressive of the notion that "we're all in it together,"

where a private system treats individuals as exclusively responsible for their own wellbeing.

- As per the arguments in the last section, a universal health care system could (at least in part by decreasing job lock) increase forms of social mobility which—though debatably a communitarian good—plausibly act as legitimating conditions for organizing structures of communities which necessarily give rise to inequalities of wealth and power. In other words, our allegiance to our communities—and hence the strength and resilience of those communities—is partly premised on the belief that positions of privilege are open to all members under fair conditions of competition, and a universal health care system helps to satisfy this legitimating condition.

Communitarianism has never been an especially well-defined view, and you can take your pick of several different articulations in constructing the normative framework. In addition to Charles Taylor and Michael Sandel, I would suggest taking a look at Michael Walzer, who defends (in *Spheres of Justice*) an interestingly nuanced communitarian view which interacts well with a lot of other moral theories in a debate round.

#### 4. Left-libertarian arguments

I'll gesture towards this position because it's associated with a literature I'd love to see more debaters check out, and because it's an interesting way of preempting one of the more common negs on the topic. In political philosophy, *libertarian* views are generally taken to be those which ascribe to individuals (a) an inviolable, or nearly inviolable right of *self-ownership* and (b) some rights of acquisition, i.e. means of acquiring property rights in previously unowned natural resources.

The spectrum of libertarian views, from right to left, is defined by the scope of this latter right. *Right-libertarians* see rights of initial acquisition as fairly extensive, such that (to give a representative version of the view) an individual can acquire ownership rights to a resource by any act of labor that adds significant value to the resource, as long as he or she does not thereby acquire a wildly disproportionate share of that particular resource. *Left-libertarians* look for stronger constraints on initial acquisition (usually expressed as interpretations of the famous Lockean proviso). For instance, on a left-libertarian view, individuals might be entitled to appropriate only a proportionate share (i.e., one seven-billionth) of any given resource, and any private acquisitions beyond this limit must receive some sort of democratic sanction and/or be

compensated by payment of market value for the resource, either to the state or through the state to individuals (as a sort of resource dividend).

Some left-libertarians (e.g. Peter Vallentyne) see natural human endowments (talents etc.) as a good akin to natural resources in this regard, to which individuals have no special moral entitlement simply by being born with them, any more than they have a special claim to natural resources by being born *near* them. A view of this nature might argue for a universal health care system in two ways: first, as part of a scheme of entitlements which serves to distribute the surplus value of natural resources, which the appropriators of those resources owe to the rest of humanity, and second, as a means of equalizing (as far as possible) the natural endowments of physical health which arbitrarily disadvantage some individuals.

What's notable about these arguments is that, despite their egalitarian flavor, they're essentially negative-rights-based and deontological. The claim is that individuals enter the world with a claim, akin to a property right, to a proportionate share of the available endowment of opportunity, and to the extent that one individual's *de facto* possession of a given resource interferes with the realization of that claim, it's akin to theft. Nevertheless, unlike (say) a Rawlsian or Marxist egalitarian position, a typical left-libertarian would have no objection to inequality as such, even radical inequality, as long as it came about by morally legitimate (rights-respecting) means from a morally legitimate starting point. Thus, these positions coopt many features of the rights-theoretic libertarian negatives we'll examine in a moment.

## Negating

### 1. *Consequentialist arguments*

Consequentialist negative ground is approximately the mirror image of consequentialist affirmative ground: a set of links to health outcomes, another set of links to cost, and whatever terminal impacts ensue therefrom. The only difference is that negatives have a slightly more interesting range of advocacies to choose from in order to generate uniqueness.

With respect to health outcomes, there are two central arguments:

- A universal health care undermines many of the ordinary quality incentives which exist in private markets. Especially in a single-payer system, but to whatever degree the government wields power in the market, the best doctors and hospitals lose the

negotiating leverage to exact a premium for the quality of the care they provide, and as a result the incentives to provide the best care are attenuated.

- Because a universal health care system will inevitably cut reimbursements to providers below market levels in order to save money, while at the same time enabling consumer to access medical services for free, the result will be undersupply of services (market rates being those at which supply matches demand, when the price falls below market rates, there is more demand and less supply). This undersupply can only be negotiated by some combination of explicit rationing (based on perceived need) and implicit rationing (based on wait times for services). Even if these mechanisms are not any less efficient than market rationing based on price (and there are some obvious reasons to believe they might be), the decrease in supply means that fewer total people receive treatment, and those who do, receive it in a less timely manner.

There are also two closely related reasons to think that a universal health care system might cost more than an equivalent private system:

- As with quality incentives, so with cost incentives. Private markets incentivize cost savings far more strongly than governments, since private actors stay in business by turning a profit where governments can finance themselves indefinitely by taxation, so all things being equal, a government will spend more than a private corporation to do the same thing. (Of course, unless the affirmative defends a complete nationalization of the health care system—and there's no reason any affirmative should—the *providers* will still be subject to more or less ordinary market incentives for cost control, and as we saw, it's debatable whether private *insurers* do their job more efficiently than a government could, so think about how to frame this argument to account for those answers.)
- A universal health care system will lead to overconsumption of services. Although we often talk as though any service which provides genuine cost benefits is worth the cost, health is in reality just one of many goods we can spend our resources on, and of only finite value. In a private market, willingness to pay (at minimum, a copay or deductible) helps limit the consumption of health care services to efficient levels, but if those services are free, there will be no disincentive to



consuming any service which might produce some health benefit, and in many cases these potential benefits will not be worth the cost of providing the service. The cost of supplying everyone with all the medical services they'll accept for free could be enough to bankrupt the entitlement system. (Note that this argument produces a double-bind with the rationing argument.)

The options for impacting are roughly the same as for the affirmative—let health and economic wellbeing serve as your terminal impacts, or make them the links into a larger, more generic impact scenario.

Spend some time thinking, though, about what negative world you want to defend in order to generate uniqueness, and consider the possibility of defending an explicit counterplan or counter-advocacy for this purpose. The two most straightforward options for negatives are (1) Obamacare, if it's negative ground and (2) the *status quo ante*, i.e. repealing Obamacare and reverting back to the way things were before 2009. But you can probably find ground which is better than either of these, by reading some of the suggestions economists have put forward for building a better private health care system. Your advocacy might start by repealing the tax exemption for employee health benefits which has contributed more than anything else to the wildly inefficient and patently irrational system of employment-based health insurance which Obamacare leaves largely untouched. It might also involve reforms to the patent system which allows drug companies to artificially prolong patent protections and charge monopoly rents for patented drugs even when functionally equivalent generics are available on the market. But I'll leave it to you to investigate the economics literature and see what you can turn up. If you can design an advocacy which include specific solvency for most of the stock affirmative advantages, you'll have to worry much less about the size of your own impacts, which will make it easier to debate the comparative cost-efficacy of competing systems without having to spend time on extraneous impact magnification.

## *2. Right-libertarian arguments*

This is the most direct route to a negative ballot: the only legitimate task of governments is to enforce a stringent scheme of negative rights (mainly ownership rights, beginning with self-ownership and extending to ownership of land, objects, and more abstract goods), and the provision of health care is not covered by this mandate. Put differently, the existence of the above scheme of rights morally prohibits any coercive redistribution of goods from one individual to another, and any coercive restriction on voluntary economic interactions.

By default, these arguments will be framed in terms of a standard like “autonomy” or “agency,” but it’s worth remembering that they’re most obviously arguments about property rights, which may or may not trace back to a “right to autonomy” (absent some variant of Nozick’s “taxation is slavery” argument).

The arguments that have the most direct connection to autonomy concern the rights of patients and doctors to freely enter into economic arrangements with one another (to buy and sell services, respectively, at any agreed-upon price). Whether and how these rights might be threatened depends on the details of the affirmative world—for instance, what sort of regulatory control the government exerts over health care providers, whether patients are permitted to buy supplemental insurance, whether a doctor can refuse to accept state-insured patients or can charge a premium beyond the state-decreed reimbursement for a given service, and so on. Most plausible forms of universal health care put some limits on the freedom of doctors and patients to enter into mutually agreeable economic arrangements, and/or so greatly undercut the negotiating power of doctors and hospitals that they have functionally no choice but to sell their services at the state’s price, so these arguments provide additional offense to libertarian frameworks. But make sure you’re as clear as possible on what the affirmative’s defending so that you can make these links maximally clear and specific.

### *3. Constitutionality arguments?*

When we debated this topic at VBI this summer, I heard debaters talking about constitutionality arguments on the negative, and I imagine at least somebody will try to put such a position together. As far as I can tell, though, it’s kind of a non-starter. If the affirmative is defending Obamacare, then of course you can always argue that the majority got it wrong when they ruled it constitutional, but arguing against explicit precedent looks like an unstrategic uphill battle, and as we saw earlier, Obamacare is very likely not affirmative ground in the first place. If the affirmative’s defending single-payer (as I hope will be more common), I’m not sure what the constitutional objection would be, other than the sort of broad libertarian objections to the expansion of the Commerce Clause which would rule out as unconstitutional most of what the federal government spends its money on. Those arguments are out there, and I’m moderately sympathetic to them in a non-debate context, but they require you to do more work than is worth it in an NC, so I’d recommend against them as debate arguments.

## **Conclusion**

So, those are some possibilities, but of course there's a lot more out there. As on any topic, research will reward you with original and unexpected positions, so do your reading and learn a little bit about the economics and history of the American health care system so that you can put arguments in context and generate more, smarter responses. Good luck and have fun!

## Topic Analysis by Adam Torson

My only complaint about this topic is that we don't get to debate it longer. It is extremely relevant and has tons of interesting lines of argument. I strongly encourage everyone to dig in and enjoy it.

### Interpretation

#### A. United States

The most straightforward interpretation of the resolution is that the agent is the United States federal government. Some affirmatives might think it advantageous to try to advocate for state-based healthcare policies (presumptively to avoid federalism disadvantages and 50 state counterplans). I don't think this makes sense both because it's a counterintuitive reading of the term "United States" and because it would be hard for state-based programs to be described as "universal." So, you should be ready to debate the "state versus federal" issue.

More specifically, the agent is probably Congress. In an election season, politics arguments (which posit advantages or disadvantages because of the political fallout of Congress enacting a universal healthcare system) will be common. Be sure to prepare blocks on both sides of major policy questions likely to be affected by the upcoming election.

#### B. Guarantee Universal Health Care

##### 1. Universal Healthcare Systems

There are a variety of health care systems which might claim to provide "universal" coverage. Each of the following are likely to become plans and counterplans, and to be the subject of topicality arguments. So, you should think about the advantages and disadvantages of each type of healthcare system, and whether each constitutes a "universal" system.

*Single-Payer System.* A single-payer system is one in which the government pays for all healthcare services. All medical treatment is financed through tax revenues. Healthcare providers themselves may be either employed directly by a National Health Service, or may be private parties who are paid only by the government. Insofar as everyone's medical care can be covered by the government, the healthcare system is "universal."

*Mandatory Insurance.* Some healthcare systems require that individuals carry health insurance with sufficiently broad coverage to pay for the normal range of health maladies. Sometimes such policies mandate coverage from private firms, and some allow coverage either by private firms or public entities. Because everyone has health insurance by law, the healthcare system can justifiably be characterized as universal.

It is an open question whether the individual mandate in the Patient Protection and Affordable Care Act (popularly known as Obamacare) can be reasonably described as Universal Health Care. It is, in a sense, a system of mandatory insurance. However, the penalty one pays for not having coverage is low enough that some may choose to pay it and forgo insurance, and it has been characterized by the Supreme Court among others as a tax rather than a penalty. So, whether this particular insurance mandate may or may not constitute Universal Health care is an open question.

*Public Options.* Some systems seek to create a government-provided alternative for individuals who cannot get coverage from private insurers. Making the government an “insurer of last resort” or providing a “public option” to supplement private insurance arguably creates universal coverage because it means that everyone is *eligible* for health insurance (public or private), even if they choose not to take advantage of it.

*Guaranteed Emergency Care.* In many countries the law requires that medical facilities give people emergency medical treatment regardless of their ability to pay for it. Some have imagined that this constitutes a form of universal coverage because nobody is denied life saving treatment. This is an implausible interpretation, however. Most definitions of “universal healthcare” imagine a basic minimum guarantee of access to healthcare that is significantly more robust than simply access to emergency care.

## 2. What is covered?

Universal coverage is generally understood to mean more than just that all people have *some* medical insurance. It also means that people have coverage for a basic range of services thought to be essential to maintaining health and combating disease and injury. What exactly is covered obviously depends on a number of variables. When evaluating healthcare systems you might ask what kinds of preventative care are covered? What kinds of discretionary procedures (e.g. cosmetic procedures) are covered? Are experimental treatments ever available? Depending on how these things are defined, you may be able to argue that some types of broad-based health insurance are nonetheless not universal.

### C. Citizens

To be a citizen of the United States, one needs either to be born in the U.S., naturalized in the U.S., or born to a parent who is a U.S. citizen. This part of the resolution won't be enormously consequential with the exceptions of two types of arguments. First, be careful when affirming not to endorse an advocacy which would *also* cover non-citizens, e.g. resident aliens. While such an advocacy is extra-topical, it is difficult to imagine that it's very abusive. Still, it is probably to your advantage to avoid the theory debate.

Second, limiting the resolution to citizens probably opens up certain critical ground, e.g. kritiks of nationalism, ethnocentrism, etc. Some frontlines on these subjects would be prudent.

## Affirmative Positions

### A. Distributive Justice

Many affirmative arguments will draw on distributive justice literature. John Rawls argues that if we were to design society without knowing what our place in that society would be, we would craft rules that allow equality of opportunity and allow inequalities only when they benefit the least advantaged. Many apply this insight to the context of healthcare. In a free market system, many who are denied access to healthcare (a basic human good) are socially disadvantaged. The poor certainly fall into this category, as do members of marginalized races, ethnicities, religions, sexual identities, and genders. Each of these groups has been disadvantaged in various ways by free market health care. For instance, a private healthcare system often caters to the discretionary desires of the wealthy (cosmetic surgery, etc.) rather than on developing capabilities to service a broader base of people. A system of universal health care is one plausible way to address these disparities.

Drawing on a similar argument set, Norman Daniels argues that universal healthcare is necessary to promote equality of opportunity. Healthcare is necessary to secure the normal opportunity range for individuals in a given society; natural differences in health and socially created disparities in access to healthcare therefore undermine individuals' ability to pursue meaningful life projects. So, Daniels argues, we are obliged to make access to healthcare universal.

Finally, Amartya Sen, Martha Nussbaum, and others argue for universal healthcare on the basis of the “capabilities approach.” This position argues that there are a basic set of capabilities which people regard as fundamental to living a dignified and flourishing life, and that securing these capabilities for each person constitutes principles of distributive justice. Insofar as a free-market system denies people these basic capabilities, and therefore undermines their ability to live a dignified and flourishing life, it is unjust.

## **B. Health Economics**

The field of health economics will furnish an almost never-ending supply of arguments on this topic. What follows are a few of the highlights, but if you want to go down the rabbit hole on economics concepts on this topic there is ample literature to do so.

The most significant argument set from within this field will have to do with reducing healthcare costs. The U.S. pays an enormously high price for healthcare – must more than one would pay for the same services in other countries. Despite this massive cost inflation, our healthcare outcomes aren’t markedly better (and in some cases are worse) than countries spending much less. There are a variety of factors driving this trend, from overutilization of healthcare services to private firm’s profit motives, but advocates of universal health care claim that such a system is the best way to contain costs. There are five major arguments supporting this claim.

First, universal coverage gives everyone access to preventative care. In the long run a variety of statistical indicators show that this is cheaper than providing acute interventions for disease or emergencies. There is no need to treat someone for the flu if she never gets it because she had her flu shot.

Second, when government is a major purchaser of health services (and perhaps the only purchaser), it has tremendous bargaining power with medical service vendors (doctors, pharmaceuticals, etc.). In the debate over the PPACA (Obamacare) various interlocutors have made the claim that such bargaining power can be wielded to lower the overall cost of healthcare – in the case of the US to the tune of over \$700 billion dollars.

Third, universal coverage is able to take advantage of economies of scale and better risk pooling. Advocates of universal healthcare often point to studies indicating that government run healthcare programs are more efficient (in terms of overhead costs, etc.) than private firms. Some of this has to do with the massive size of the government’s role in the healthcare sector already. Medicare and Medicaid programs can realize economies of scale, i.e. efficiency gains simply being a larger

operation. For example, a larger operation can gather more information, avoid redundancy better, etc.

Additionally, creating an insurance pool from the entire nation helps to keep the costs of coverage down. Private insurers face the problem of adverse selection – people only join when they are sick or likely to become sick, and this forces the companies to charge higher premiums to compensate for the fact that they are paying more claims for care. When everyone is put in the insurance pool and have only to pay for the aggregated risks of disease across the entire population, there is virtually no risk of adverse selection effects driving up health costs.

Fourth, many argue that single payer systems which rely on private health service providers facilitate better transparency of health pricing and quality information. Because this information is relevant to government services, there is a central place for gathering and distributing information about what health care services are most effective and least costly. This helps improve the efficiency of the healthcare market because consumer choices are better informed.

Finally, universal care advocates believe that universal healthcare is better for the health of the economy as a whole because people are sick less often and therefore more able to make productive contributions to the economy. While this doesn't control costs in the direct sense, it does ensure that more people will be able to afford their health insurance and that the pinch of high presses is felt less acutely because we are all better off.

The impacts to these arguments can be extensive. The most immediate impact has to do with the affordability of care. The more expensive basic treatments are, the more people that will go without needed healthcare and suffer as a result. Moreover, controlling the costs of healthcare is the only way to realistically address the massive debt and deficit crisis looming over the American economy. Because an enormous proportion of government expenditures are for health services (through Social Security, Medicare, Medicaid, Veterans hospitals, etc.), higher healthcare costs drive budget deficits, which in turn drive larger debt. As you can imagine, debt crisis and economic disaster can be spun into all kinds of impact scenarios.

### **C. Humanitarianism**

While many of the internal links in these positions will be similar to those listed above, the focus will be somewhat different. Poverty and ill-health aren't simply states of material deprivation; they are characterized by a loss of hope and human dignity. The physical suffering caused by ill-health is visceral to us, yet we too often ignore the scope of the problem. A stock but compelling position



will argue that nobody whose moral relevance we recognize should be subject to that kind of mental or physical suffering.

These issues will be illustrated in terms of the debate over whether insurance companies have to cover people with pre-existing conditions. The PPACA makes it illegal to deny someone health insurance because of a pre-existing medical condition. The argument for this is that it ensures that the people who need it most will have access to healthcare, and insurance companies will not be able to wriggle out of their insurance policies. However, forcing firms to insure people with pre-existing conditions creates a collective action problem. People will simply wait until they get sick to join an insurance program; if everyone does this, insurance risk pooling is eliminated and the system becomes financially unsustainable. In other words, there is nobody paying premiums who is not taking out more than he is putting in. Insurance companies can't afford to do business that way. So, the law also mandates universal health insurance coverage so that people are *forced* to purchase health insurance. This resolves the "free rider" problem of those who only pay into the system when they need it.

## Negative Positions

### A. Libertarianism

The major set of philosophical objections on this topic will come from libertarian authors. On the political theory side of the ledger, Robert Nozick is the standard-bearer for criticisms of social distribution of goods and services. He argues that people should be thought to own themselves and their labor, and that using them as a means to an end disrespects their fundamental personhood. Redistribution in the form of taxation, he argues, is akin to slavery. Each of us is made to work a portion of his day to benefit someone else (in this case someone who cannot otherwise secure health insurance). If this line of reasoning is persuasive, then taxpayer funded health insurance programs are almost certainly inappropriate.

Libertarians will also leverage arguments from the economics side of the ledger. Friedrich Hayek is a leading figure here. He argues that central planning of any major economic sector is guilty of a "fatal conceit," which is that somehow the government can master and utilize all the information necessary to most efficiently distribute goods in the same way that market pricing mechanisms can. This is pretty plainly an impossible task. Instead he argues that free markets are the only way to govern the distribution of goods and services in an extended society. If government controlled the provision of healthcare, there would be systematic surpluses and shortages and

other forms of economic inefficiency by simple virtue of the fact that government can't have perfect information.

#### **B. Privacy and Health Autonomy**

You don't necessarily have to go down a deeply theoretical road to make libertarian-like arguments on the topic. Many civil libertarians and privacy advocates worry about the amount of power the government claims for itself in taking on a major role in the healthcare sector. There are many concerns that fall into this general category. Some fear that electronic record-keeping will make it harder for people to protect their sensitive personal health information. More extreme critics worry about the prospects of using health information (e.g. about genetics) to discriminate against marginalized groups or to undermine civil liberties by maintaining a universal DNA database.

A related concern is that government control of the healthcare sector will harm individual freedom to select or refuse medical care they believe to be most appropriate to them. While worries about "death panels" or groups that decide who gets what treatments have been significantly exaggerated in the debate over the PPACA, at some level the government hopes to ration health care services to save costs and perhaps to advance other social agendas. Advocates of personal freedom in health decisions, a much prized constitutional right, fear that this could lead down the road to less control over one's body and personal health choices.

#### **C. Market Problems**

Many worry that a significant expansion of government's role in the health sector will undermine many of the advantages of the free market healthcare system. First, many worry that the free market most effectively creates innovations that both improve quality and reduce costs. Without the prospect of significant profits, there is little incentive to invest in risky enterprises or research projects that might ultimately yield medical breakthroughs. Doing away with private firms or attempting to control their profits through central regulation may well undermine such innovation.

Another concern is that private healthcare providers will increasingly refuse to provide service to those insured by the government. It is already the case that many clinics and hospitals won't take Medicare and Medicaid patients because the rates of expense reimbursement are simply too low to be economically viable. In other words, the government's much touted bargaining power might actually drive skilled practitioners out of the market for those depending on the government for their healthcare.

Finally, some countries have experienced professional migration or “brain drain” when the economic opportunities for healthcare professionals are less advantageous than those in other countries. Right now, practicing medicine in the United States is desirable because the market sets a relatively high rate of compensation; doctors get paid a lot. When government regulation attempts to limit those incentives, skilled professionals might go elsewhere (or never become a doctor at all).

#### **D. Counterplans**

The last type of negative argument you will commonly see will be counterplans advocating some type of healthcare distribution system (universal or otherwise) than is advocated in the AC. Some of these positions will provide for interesting clash; affirmative debaters should be prepared to defend the advantages of their advocacy not only in relation to the status quo but also in relation to plausible alternative methods of healthcare reform.

#### **Conclusion**

Enjoy this most interesting and straightforward topic while it lasts. Best of luck to everyone!

## Topic Analysis by Liz Vieira

### Background

Over the past few decades, health care has been a contentious issue in the United States. Although nearly all Americans see the need for it, paying for health care has been another story.<sup>8</sup> Health insurance, a system of cost/ risk sharing for medical care, can be provided through an employer, purchased as an individual on the open market, offered from the government for older Americans (Medicare) or for the poorest Americans (Medicaid). In 1986, Congress passed the “Emergency Medical Treatment and Active Labor Act” (EMTALA), which required hospitals to provide treatment to individuals suffering from a genuine medical emergency or in labor regardless of their ability to pay. EMTALA allowed hospitals to bill individuals after the provision of services, but frequently, hospital bills went unpaid, either because the individuals didn’t have insurance, didn’t have adequate insurance, or the individual’s portion of the payment was simply too high.<sup>9</sup> Since hospitals couldn’t recover costs from some patients, they increased the rates charged to everyone else, resulting in a de facto redistribution of costs from uninsured to insured patients. In 1994, at the urging of President Bill Clinton, Congress attempted to pass comprehensive health care reform that would result in universal coverage, but the measures failed and the debate over health care shifted from coverage to cost-control for the short term.<sup>10</sup>

In 2010, Congress passed the Patient Protection and Affordable Care Act of 2010 (“ACA” a/k/a “Obamacare”) without the support of a single Republican, attempting to provide closure to the decades-long debate over Americans’ entitlement to health care. Instead of closure, the ACA immediately prompted lawsuits and eventually culminated in the Supreme Court hearing an unprecedented three-days of argument over its Constitutionality.<sup>11</sup> On June 28, 2012, the Supreme Court upheld the majority of the law, including the individual mandate giving individuals the choice to either pay for health insurance or opt out and instead pay a tax penalty to the government.<sup>12</sup> Rather than settle the health care debate, the decision continued a vitriolic

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<sup>8</sup> I start with a broad overview because so many arguments are predicated on effective care/ cost balance and it will be essential for debaters to understand how the current system works in order to debate this topic. For a really basic and easy to understand explanation of how health care in the United States was financed prior to the passing of ACA, see Kao-Ping Chua’s essay for the American Medical Student Association, available at [http://www.amsa.org/AMSA/Libraries/Committee\\_Docs/HealthCareSystemOverview.sflb.ashx](http://www.amsa.org/AMSA/Libraries/Committee_Docs/HealthCareSystemOverview.sflb.ashx)

<sup>9</sup> Even for those with health insurance, filing bankruptcy because of medical bills is a frequent occurrence. See Tamkins, Theresa, “Medical bills prompt more than 60 percent of U.S. bankruptcies,” *CNN.com*, June 5, 2009, [http://articles.cnn.com/2009-06-05/health/bankruptcy.medical.bills\\_1\\_medical-bills-bankruptcies-health-insurance?\\_s=PM:HEALTH](http://articles.cnn.com/2009-06-05/health/bankruptcy.medical.bills_1_medical-bills-bankruptcies-health-insurance?_s=PM:HEALTH).

<sup>10</sup> For a brief, clear explanation of the history, see “Universal Access to Health Care,” *Harvard Law Review*, Vol. 108, No. 6 (Apr. 1995), pp. 1323-1340, 1323.

<sup>11</sup> See *National Federation of Independent Business et al v. Sebelius, Secretary of Health and Human Services, et al*, 567 U.S. \_\_\_ (2012). Full-text available online: <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>. (For an understandable summary, see Howe, Amy. “Today’s health-care decision: In Plain English,” *SCOTUSblog*, Jun. 28, 2012, <http://www.scotusblog.com/2012/06/todays-health-care-decision-in-plain-english/>).

<sup>12</sup> Liptak, Adam., “Supreme Court Upholds Health Care Law, 5-4, in Victory for Obama,” *New York Times*, June 29, 2012, [http://www.nytimes.com/2012/06/29/us/supreme-court-lets-health-law-largely-stand.html?\\_r=1&hp](http://www.nytimes.com/2012/06/29/us/supreme-court-lets-health-law-largely-stand.html?_r=1&hp).

discussion over health care, resulting in the House symbolically voting to repeal the law<sup>13</sup> and Republican Presidential candidate Mitt Romney stating that he would repeal the law on day one of his Presidency.<sup>14</sup>

Given the importance of health care to individuals' well-being and the significance of the political discourse on the topic, this resolution asks debaters to address a fundamental difference in approaches to governance.<sup>15</sup> Fortunately, the timeliness of the topic also means there is a lot of accessible topic literature.

### Definitions

*United States:* The United States in the resolution both provides the actor/agent for the resolution and limits the context. I think most reasonable affirmative will assume that the government is the actor since it's the only agent capable of instituting such a huge policy in the United States. Importantly, this limits the context of the debate to a familiar realm. I wouldn't automatically exclude foreign examples (i.e. France, England, Canada, etc.) from your analysis if you can show how that style of Universal Health Care ought to be a system the U.S. guarantees, but the context is nice because it allows debaters to analyze the impacts under only one political and economic system.

*Ought:* Merriam-Webster's Dictionary defines ought as "used to express obligation"<sup>16</sup> which should be good enough for this debate. A debater might want to define it as a moral obligation, but for most purposes, the idea of an obligation should be sufficient.

*Guarantee:* Oxford defines guarantee as "promise with certainty."<sup>17</sup> For this topic, this seems to indicate that there is some sort of enforceability rather than a general pronouncement that universal health care is a good thing.

*Universal Health Care:* Universal Health Care ("UHC") can cover a range of approaches to providing health care, which will make this the most important definition in the round. The World Health Organization defines universal health coverage<sup>18</sup> as

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<sup>13</sup> Haberkorn, Jennifer and Kim, Seung M., "House votes to repeal 'Obamacare'—again," *Politico.com*, July 11, 2012, <http://www.politico.com/news/stories/0712/78403.html>.

<sup>14</sup> Hampton, Adele, "Romney campaign: 'Day one. Job one. Repeal Obamacare,'" *The Hill*, June 28, 2012, <http://thehill.com/video/campaign/235499-romney-campaign-day-one-job-one-repeal-obamacare>. Shortly after the first tournament on this topic, we'll know whether Romney will be in a position to do so.

<sup>15</sup> Notably, "approaches to government" in the health care context need not mean a conservative/ liberal split. See Roy, Avik, "The Tortuous Conservative History of the Individual Mandate," *Forbes*, February 7, 2012, <http://www.forbes.com/sites/aroy/2012/02/07/the-tortuous-conservative-history-of-the-individual-mandate/> (regarding early Republican support for the individual mandate) and Cohen, Elizabeth, "Longtime Republicans torn between party loyalty and Obamacare" *CNN.com*, October 6, 2012, <http://www.cnn.com/2012/10/06/health/republicans-conflicted-obamacare/index.html> (regarding Republican support for ACA despite dislike of President Obama).

<sup>16</sup> <http://www.merriam-webster.com/dictionary/ought>

<sup>17</sup> <http://oxforddictionaries.com/definition/english/guarantee>

Universal health coverage is defined as ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services.<sup>19</sup>

A lot of the literature will talk about ACA, and ACA is a good example of UHC, but there are affirmative positions that could defend other iterations of UHC. Pay attention to the sources you are using to make sure they are talking about the same system (and make sure your negative responses answer whatever form the affirmative is defending). Other systems to look at include single-payer private delivery (Canada), single-payer government delivery (Great Britain), private payer with a public back up (Medicare/ Medicaid) and anything in-between.<sup>20</sup> Some authors consider a wholly private system with a minimal assurance of care (like EMTALA) to be UHC because individuals cannot be denied needed medical care.<sup>21</sup> There might be some merit to this interpretation, but pay attention to the impacts that [a](#) debater arguing this position uses—a lot of the benefits of universal health care come from preventive/ non-emergency approaches to treatment.

*Citizens:* According to Merriam-Webster's Dictionary, a citizen is "a native or naturalized person who owes allegiance to a government and is entitled to protection from it." I don't think there will be problems with this word in the resolution and it is there more because the phrase "universal health care" needs a recipient rather than for any special interpretational reason.

## Framework

The way you frame the evaluative mechanism for the debate is going to be really important on this topic because the core of the resolution is a disagreement over whether individuals are due anything from others. I don't suspect we'll see a lot of agreement between affirmatives and negatives on how to evaluate impacts. Ultimately, I think most rounds will come down to a fundamentally different worldview in which the affirmatives argue that health care is a right that society must guarantee and negatives argue that health care isn't a right and individuals shouldn't be forced to sacrifice so that others can get care. Debaters would be wise to examine the assumptions and justifications for these positions because in many rounds, defining the way the United States ought to be will be key to determining whether it ought to guarantee health care.

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<sup>18</sup> I realize this definition is for "coverage" rather than care, but for a basic framing of the topic, I like the general approach that encompasses access to an assortment of defined health care services.

<sup>19</sup> [http://www.who.int/topics/universal\\_health\\_coverage/en/](http://www.who.int/topics/universal_health_coverage/en/)

<sup>20</sup> For a look at a number of systems, as well as the economics of those systems, see Besley, Timothy, Gouveia, Miguel, and Dreze, Jacques, "Alternative Systems of Health Care Provision," *Economic Policy*, Vol. 9, No. 19, (Oct. 1994), pp. 199-258.

<sup>21</sup> See, e.g., Besley, et. al. at n. 1.

### A Note on Constitutionality

The U.S. Constitution provides a basis for federal power in the U.S. The Supreme Court decision on the Constitutionality of ACA affirmed that Congress could assess a tax on people who opted out of the health insurance market. As the case was argued through the courts, the government had primarily argued that the individual mandate was permitted under the Commerce Clause.<sup>22</sup> Ostensibly, this “social responsibility tax” would be used to offset the emergency care sought by people who do not have insurance, correcting one of the biggest problems with EMTALA. The Constitution does NOT guarantee health care, but, after this decision, it does seem to permit it under Congress’ taxing authority. I bring this up for two reasons: first, Affirmatives should not construct cases around the idea of constitutionality because it only *permits* the guarantee of health care, but doesn’t require it<sup>23</sup> and second, if an affirmative chooses to defend some iteration of UHC other than ACA, it would be wise to make sure there is a justification (Constitutional or otherwise) for that power. Simply put, the Court found that the United States *can* provide UHC, not that it *ought*.

### Affirmative Arguments

#### *Veil of Ignorance*

The core conflict of this resolution has been debated at length by two philosophers-- John Rawls and Robert Nozick. John Rawls theorized that we should define justice as fairness and evaluate justice by the policies we would create behind a “veil of ignorance” in the original position. According to Rawls, in the original position,

[N]o one knows his place in society, his class position or social status, nor does any one know his fortune in the distribution of natural assets and abilities, his intelligence, strength, and the like. I shall even assume that the parties do not know their conceptions of the good or their special psychological propensities. The principles of justice are chosen behind a veil of ignorance. This ensures that no one is advantaged or disadvantaged in the choice of principles by the outcome of natural chance or the contingency of social circumstances. Since all are similarly situated and no one is able to design principles to favor his particular condition, the principles of justice are the result of a fair agreement or bargain.<sup>24</sup>

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<sup>22</sup> “A Clean Bill of Health,” *The Economist*, Jun. 28, 2012, <http://www.economist.com/blogs/democracyinamerica/2012/06/obamacare-and-supreme-court?zid=318&ah=ac379c09c1c3fb67e0e8fd1964d5247f>

<sup>23</sup> You could also argue that there *ought* to be a statutory or Constitutional right to health care that hasn’t been recognized yet. See explanation below.

<sup>24</sup> Rawls, John. “Justice as Rational Choice Behind a Veil of Ignorance.” *Justice: Alternative Political Perspectives*, Ed. James P. Sterba, Wadsworth Publishing Co., 1999. pp. 110-11. (The excerpt in this anthology is an edited essays taken from Rawls’ book *A Theory of Justice*, Harvard University Press, 1971.)

Rawls concludes that, behind the veil of ignorance, people would choose two principles:

[T]he first requires equality in the assignment of basic rights and duties, while the second holds that social and economic inequalities (for example, inequalities of wealth and authority) are just only if they result in compensating benefits for everyone, and in particular for the least advantaged members of society.<sup>25</sup>

You could argue that in the original position, in which someone didn't know if they would be healthy or ill, rich or poor, or any have any other characteristic that would disadvantage them, they would choose a society that provided universal health care. If it's something a just society would do, then the United States ought provide a right to health care. A lot of the literature affirming on this topic explicitly argues for a Rawlsian conception of justice, so it shouldn't be hard to find evidence for this position.<sup>26</sup>

#### *Health Care as a Right*

Although most affirmative positions will imply that health care is a right, you could set up a position to explicitly justify the right. One way to argue it would be that individuals have a right to be protected from external harm, diseases are external harms, therefore the state has a responsibility to protect individuals from the threat of disease. For example,

In conclusion, if the proper function of the State is to provide basic protection to its citizens, there seems to be a basis for the right to at least minimal health care. At the national level, the State is charged with the protection of the national citizenry. In so far as this refers to the citizenry taken as individuals, it would seem that the State has an obligation to protect individuals from threats to life.<sup>27</sup>

You could also argue that the state ought define and create a right to health care. Although the Constitution doesn't provide a right to health care, a legal right could be created by statute. This would provide a stronger legal basis to enforce universal health care.

A legal right to health care need not be constitutional in nature. It could be created by statute. A statute could declare the broad outlines of a right to health care, setting the

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<sup>25</sup> Rawls at 112.

<sup>26</sup> See e.g. Rice, Thomas, "Individual Autonomy and State Involvement in Health Care," *Journal of Medical Ethics*, Vol. 27, No. 4, (Aug. 2001), pp. 240-244, (presenting arguments both for and against universal health care and concluding that the benefits of universal access outweigh the disadvantages) and Karsten, Siegfried G., "Health Care: Private Good vs. Public Good," *American Journal of Economics and Sociology*, Vol. 54, No. 2, (Apr. 1995), pp. 129-144 (explaining the economic classification of health care as a private, semi-private, and public good).

<sup>27</sup> Jones, Gary E. "Health Care and The State," *Philosophical Quarterly*, Vol. 33, No. 132, (July 1983), pp. 279-287, 287.



stage for the creation of a comprehensive system of universal access to health care. For example, Congress could pass legislation akin to the Canada Health Act, which requires the provinces to provide healthcare that is universal, accessible, portable, comprehensive and publicly administered, in return for federal funding. Although the Act subsequently has been elaborated by legislation and judicial interpretation it set the foundation for comprehensive access to health care. In the United States, this approach would have the advantage of capitalizing on the popular consensus that Congress should act on the problem of access to health care without presenting the obstacles of constitutional amendment.<sup>28</sup>

If health care is a right, then it follows that the U.S. ought to guarantee universal access to it.<sup>29</sup>

### *International Treaties*

A number of international treaties also provide for a right to health care. The Universal Declaration of Human Rights declares that individuals have a right of access to health care. You might argue that the United States ought to have universal health care to fulfill our obligations under this treaty. According to the Universal Declaration of Human Rights,

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.<sup>30</sup>

The Office of the United Nations High Commissioner for Human Rights explains that access to health care is a fundamental right of all people because:

As human beings, our health and the health of those we care about is a matter of daily concern. Regardless of our age, gender, socio-economic or ethnic background, we consider our health to be our most basic and essential asset. Ill health, on the other hand, can keep us from going to school or to work, from attending to our family responsibilities or from participating fully in the activities of our community. By the same token, we are

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<sup>28</sup> Sandhu, Puneet K. "A Legal Right to Health Care: What Can the United States Learn from Foreign Models of Health Rights Jurisprudence?" *California Law Review*, Vol. 95, No. 4, (Aug. 2007), pp. 1151-1192, 1156-57.

<sup>29</sup> For a potential legal framework for applying a subsistence right to healthcare, see Good, Martha H., "Freedom from Want: The Failure of United States Courts to Protect Subsistence Rights," *Human Rights Quarterly*, Vol. 6, No. 3, (Aug. 1984), pp. 335-365.

<sup>30</sup> Universal Declaration of Human Rights, Art. 25, para. 1. Other international treaties that recognize this right include the International Covenant on Economic, Social, and Cultural Rights and the Charter of the Organization of American States. See Good, "Freedom from Want" at 361 for more examples.

willing to make many sacrifices if only that would guarantee us and our families a longer and healthier life. In short, when we talk about well-being, health is often what we have in mind.<sup>31</sup>

These treaties are generally not binding on the U.S., but you could argue that the U.S. has an obligation to adhere to them. Even if we aren't morally or legally obliged to follow international law, the reasoning behind these treaties and covenants provides salient justifications for providing universal health care.

#### *Health is Foundational to Participating in a Democracy*

The other positions assume that there is an intrinsic value to people being healthy. That's not necessarily a bad assumption, but an interesting case could be built around examining *why* it's important that citizens are healthy. Some authors argue that health is important to citizenship, and since we know we are talking about the United States, democratic participation and values are important. Health care facilitates a better democracy because

The political ground for a right to health care is that it is instrumental for effective citizenship and the exercise of other fundamental rights. Effective citizenship requires not only civil rights like voting and freedom of speech, but also the satisfaction of basic needs. Ill health may compromise or eradicate a person's liberty, autonomy, and exercise of the franchise. Healthy citizens are more likely to engage in, and thus contribute to, a robust democratic process. Put more broadly, civil and political rights and social rights are not distinct but interdependent; the exercise of civil and political rights depends on the fulfillment of social rights. Essentially, by producing health, a right to health care promotes active participation in society by the greatest number of citizens.<sup>32</sup>

UHC thus makes citizens better citizens and is a policy the United States ought to pursue.<sup>33</sup> You might also argue that the exercise of most other rights require a basic level of health and the United States ought to protect health as a prerequisite to exercise of those rights.

#### **Negative Arguments**

##### *Nozick's Minimalist State*

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<sup>31</sup> <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>

<sup>32</sup> Sandhu, "A Legal Right to Health Care" at 1156-57.

<sup>33</sup> See also Campbell, Alastair V. *Health as Liberation: Medicine, Theology, and the Quest for Justice*, Cleveland, Ohio: The Pilgrim Press, 1995.

Robert Nozick wrote in response to John Rawls and argues for a “minimalist state.”<sup>34</sup> His position is that the sole function of government is protection from external threats, and government must avoid infringing on individual liberty by requiring one individual to undergo a sacrifice for the benefit of another. He notes:

Taxation of earnings from labor is on a par with forced labor. Some persons find this claim obviously true: taking the earnings of  $n$  hours labor is like taking  $n$  hours from the person; it is like forcing the person to work  $n$  hours for another's purpose. Others find the claim absurd. But even these, if they object to forced labor, would oppose forcing unemployed hippies to work for the benefit of the needy. And they also would object to forcing each person to work five extra hours each week for the benefit of the needy. But a system that takes five hours' wages in taxes does not seem to them like one that forces someone to work five hours, since it offers the force a wider range of choice in activities than does taxation in kind with the particular labor specified.<sup>35</sup>

The argument would be that UHC (even non-ACA UHC, but especially ACA) is a form of tax that requires someone to undergo work for another. If person A never uses health care, but is forced to pay for health care for person B, person A has been sacrificed for the greater good. Nozick argues that using people as a means to an end is always a bad thing. This position still works without an explicit tax because even if individuals were required to purchase private insurance, the healthy person's insurance premiums would subsidize a sick person's health care.

#### *Government Shouldn't Be Involved in Health Care Decisions*

This is a more nuanced version of the “death panels” argument that was launched in response to the proposal of ACA. If UHC exists, inevitably, *someone* is deciding what is/ isn't universally covered. This gives the government an expanding ability to interfere with health care decisions. This struggle is most popularly played out over issues like abortion and contraceptives, but also appears in other ways, like whether health insurance should cover reconstructive surgery after a mastectomy or corrective plastic surgery to reduce the appearance of scars from injury or surgery. If the government is the one paying (or paying and providing), it gets to decide what is and isn't “health care” and, this position would argue, a role the government shouldn't play.

There are other significant concerns about making the government both a payer and provider and the potential for interference with the Doctor-Patient relationship. Carolyn Tuohy outlines them, with a focus on the government's incentive to decrease costs of care:

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<sup>34</sup> Nozick, Robert. *Anarchy, State and Utopia*. New York: Basic Books, 1974.

<sup>35</sup> Nozick, Robert, “Distributive Justice,” *Philosophy & Public Affairs*, Vol. 3, No. 1 (Autumn 1973), pp. 45-126, 65.

As long as the role of the state in the health care arena was focused on the regulation of quality, this second-level agency relationship was a fairly stable arrangement. The large-scale entry of states into the financing of health care, however, had important implications for established agency relationships between the state and provider groups. First, it signaled the state's interest in the distribution as well as the quality regulation of health care services. Second, it gave governments a major stake in the costs as well as the quality of health care services. And third, it created the potential (and at first only the potential) to assemble large databases of patient and provider records in the course of administering government programs of health care coverage.<sup>36</sup>

There are also empirics regarding the dangers of government provision of health care, such as rationing that occurs when the demand exceeds the available supply.

Thus explicit rationing would be a political control system. It would begin with a budgetary allocation of resources and proceed through a system of controls to set limits to facilities, manpower and its distribution, technical innovation and finally to the clinical judgment of doctors. 'Explicit rationing' does not mean that every individual is guaranteed equal access to appropriate medical care or equal shares. Treatment is still within the postulate that the doctor will do his best with the resources available to him but there are now such constraints on those resources as government decides; the end product is (as Mechanic says) bureaucratic medicine, governed by political decisions.<sup>37</sup>

The impacts to this type of argument can vary from "the affirmative can't access their claimed advantages" to "UHC is a government conspiracy used to control populations." Use your imagination and research skills.

#### *Universal Health Care Stifles Innovation in Medicine*

One of the primary concerns in developing a UHC system is to make sure that incentives are properly created or maintained. There are a number of arguments here, including the fear that individuals won't choose to enter the medical profession if it isn't possible, resulting in more demand than supply for doctors; a concern that medical research will stall because hospitals won't need to expand their services to attract new patients; a concern that health care providers won't work toward more efficient management practices because they will be paid a set-fee

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<sup>36</sup> Tuohy, Carolyn H. "Agency, Contract, and Governance: Shifting Shapes of Accountability in the Health Care Arena," *Journal of Health Politics, Policy and Law*, Vol. 28, Nos. 2-3, (April-June 2003), pp. 195-215, 199.

<sup>37</sup> Office of Health Economics (London), "Scarce Resources in Health Care," *The Millbank Memorial Fund Quarterly. Health and Society*, Vol. 57, No. 2, (Spring 1979), pp. 265-287, 275.

regardless of how well or poorly they perform; and drug manufacturers would have no incentive to create new drugs because their profits would be limited. All the variants of this argument require a basic understanding of economics, so debaters would be wise to review those before engaging in these arguments.

### *Rights Talk*

The tendency to label everything a “right” devalues actual rights. If the affirmative labels health care a “right”, it contributes to the devaluing of our political discourse. The problem, according to Mary Ann Glendon, is

Our rights talk, in its absoluteness, promotes unrealistic expectations, heightens social conflict, and inhibits dialogue that might lead toward consensus, accommodation, or at least the discovery of common ground. In its silence concerning responsibilities, it seems to condone acceptance of the benefits of living in a democratic social welfare state, without accepting the corresponding personal and civic obligations. In its relentless individualism, it fosters a climate that is inhospitable to society's losers, and that systematically disadvantages caretakers and dependents, young and old. In its neglect of civil society, it undermines the principal seedbeds of civic and personal virtue. In its insularity, it shuts out potentially important aids to the process of self-correcting learning. All of these traits promote mere assertion over reason-giving.<sup>38</sup>

While I’m not normally a huge fan of positions that can be run on any topic, I think rights talk is specifically applicable to this topic because the link (discussing a right) is likely to be intentional (rather than a casual slip-up) and because there is literature that specifically addresses how defining health care as a right influences political discourse.<sup>39</sup> Although the position itself is critical, I think this argument can be run as a standard negative case because it directly refutes the resolutional question.

### **Conclusion**

There’s a lot of potential for good, politically relevant arguments on this topic. Have fun and enjoy debating it!

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<sup>38</sup> Glendon, Mary Ann. *Rights Talk: The Impoverishment of Political Discourse*, New York: The Free Press, 1991.

<sup>39</sup> See, e.g., Redden, Candace J., “Health Care as Citizenship: Examining Social Rights and Entitlement,” *Canadian Journal of Political Science*, Vol. 35, No. 1, (Mar. 2002), pp. 103-125 (explaining the process of “cutting through rights talk” to identify what the “right to health care” means) and Levitsky, Sandra R., “‘What Rights?’ The Construction of Political Claims to American Health Care Entitlements,” *Law & Society Review*, Vol. 42, No. 3, (Sept 2008), pp. 551-590.

## FRAMEWORK EVIDENCE

### THE PRINCIPLE OF EQUAL ACCESS TO HEALTHCARE DEFINED

Amy Guttmann [Professor of Political Science, Communications, and Philosophy, University of Pennsylvania], "For and Against Equal Access to Healthcare," *The Milbank Memorial Fund Quarterly. Health and Society*, Vol. 59, No. 4 (1981), pp.542-560

A principle of equal access to health care demands that every person who shares the same type and degree of health need must be given an equally effective chance of receiving appropriate treatment of equal quality so long as that treatment is available to anyone. Stated in this way, the equal access principle does not establish whether a society must provide any particular medical treatment or health care benefit to its needy members. I shall suggest later that the level and type of provision can vary within certain reasonable boundaries according to the priorities determined by legitimate democratic procedures. The principle requires that if anyone within a society has an opportunity to receive a service or good that satisfies a health need, then everyone who shares the same type and degree of health need must be given an equally effective chance of receiving that service or good.

Since this is a principle of equal *access*, it does not guarantee equal *results*, although it probably would move our society in that direction. Discriminations in health care are permitted if they are based upon type or degree of health need, willingness of informed adults to be treated, and choices of lifestyle among the population. The equal access principle constrains the distribution of opportunities to receive health care to an egalitarian standard, but it does not determine the total level of health care available or the effects of that care (provided the care is of equal quality) upon the health of the population. Of course, even if equality in health care were defined according to an "equal health" principle (Veatch, 1976), one would still have to admit that a just health care system could not come close to producing an equally healthy population, given the unequal distribution of illness among people and our present medical knowledge.

## **SINGLE PAYER SYSTEM DEFINED**

Kao-Ping Chua [AMSA Jack Rutledge Fellow 2005-2006] and Flávio Casoy [AMSA Jack Rutledge Fellow 2007-2008], "Single Payer 101," AMSA, Web. (2008) Accessed 15=3 Oct. 2012.

Single payer refers to a way of financing health care, which includes both the collection of money for health care and reimbursement of providers for health care costs. In a single payer system, both the collection of funds and the reimbursement are the responsibility of one entity: the government. The government collects funds from individuals and businesses, mainly in the form of taxes, and the government reimburses providers for health care services delivered to individuals enrolled in the public health insurance program.

## **SINGLE PAYER DISTINGUISHED FROM SOCIALIZED MEDICINE**

Kao-Ping Chua [AMSA Jack Rutledge Fellow 2005-2006] and Flávio Casoy [AMSA Jack Rutledge Fellow 2007-2008], "Single Payer 101," AMSA, Web. (2008) Accessed 15=3 Oct. 2012.

Importantly, the term "single payer" is different from "socialized medicine" and "universal health care." Socialized medicine refers to a system like the National Health Service of the U.K., in which the mechanisms of delivery of health care are owned by the government. That is, the government owns the health care facilities and physicians work for the government. In contrast, the mechanisms of delivery of health care in a single payer system are not necessarily owned by the government. Physicians can be either in private practice or public practice, and hospitals can be both publicly or privately owned. In Canada, for example, physicians are predominantly in private practice, while hospitals are both public and private. As another example, American physicians and hospitals that take care of Medicare patients are usually private. Single payer does not specify a health care delivery mechanism; it specifies a health care financing mechanism.

The term "universal health care", in a general sense, refers to providing every citizen of a country with health insurance. Although universal health care connotes a national public insurance program to some people, there are in reality a variety of ways of achieving universal health care, some of which are predominantly public, and others of which use a mixture of public and private elements. Single payer is one way of achieving universal health care, but other ways include the multi-payer systems of Germany and Japan.



**THE SUPREME COURT HAS UPHELD THE CONSTITUTIONALITY OF AN INDIVIDUAL HEALTH INSURANCE MANDATE AS AN APPLICATION OF CONGRESS'S POWER TO TAX**

Barry Friedman [Prof. of Law, NYU School of Law], "Obamacare and the Court Handing Health Policy Back to the People," 91 Foreign Aff. 87 (2012)

On June 28, 2012, when the Supreme Court announced its ruling, both the way the individual justices voted and the reasoning of the decision came as a shock to almost all Court watchers. The chief justice had crossed partisan lines, writing the lead opinion upholding the individual mandate by a five-to-four vote. The other conservative justices, meanwhile, wrote an unusual jointly authored dissent.

The Court's reasoning in preserving the individual mandate proved even more unexpected. Roberts and the conservatives agreed that the individual mandate exceeded the power of Congress to regulate commerce. But Roberts then pivoted, joining with the Court's four liberals in holding that the mandate could be characterized not as a penalty but as a tax and so was well within Congress' broad power to tax for "the general welfare." Thus, the Court spared the individual mandate and upheld most of the ACA.

## HEALTHCARE COSTS IN THE UNITED STATES ARE EXTREMELY HIGH

Ezekiel J. Emanuel [MD, PhD; Department of Bioethics, The Clinical Center, National Institutes of Health] and Victory R. Fuchs [Prof. Department of Economics, Stanford University], "The Perfect Storm of Overutilization," *JAMA*, Vol 299, No. 23 (June 18, 2008)

The United States spends substantially more per person on health care than any other country, and yet US health outcomes are the same as or worse than those in other countries.<sup>1,2</sup> In 2005, the last year for which comparative statistics are available, the United States spent \$6401 per person, whereas the next highest spending was in Norway and Switzerland, \$4364 and \$4177, respectively (TABLE).<sup>3,4</sup> Overall, US health care expenditures are 2.4 times the average of those of all developed countries (\$2759 per person), yet health outcomes for US patients, whether measured by life expectancy, disease-specific mortality rates, or other variables, are unimpressive (Table).<sup>1,3,4</sup>

**FRAGMENTED PRIVATE SYSTEMS ARE INEFFICIENT, BUT HEALTHCARE REFORM IS LARGELY A POLITICAL ISSUE.**

Stuckler, David [University of Oxford, UK; London School of Hygiene and Tropical Medicine, UK], Andrea B. Feigl [Harvard School of Public Health, USA], Sanjay Basu [University of California San Francisco, USA], and Martin McKee [London School of Hygiene and Tropical Medicine, UK]. "The Political Economy of Universal Health Coverage," *Background paper for the Global Symposium on Health Systems Research*. November 16-19, 2010.

Choices about how to organize the health system today impact the way it develops tomorrow. The establishment of universal public systems early on will avoid stigma associated with public/private systems and facilitate more equitable provision. Fragmented private systems tend to be more costly and less efficient at achieving public health goals. Leaders of low- and middle-income countries make choices that create and strengthen those with vested interests in the design of healthcare systems and lock those systems into trajectories that become very difficult to change later on (exemplified by the experience of attempts to expand coverage in the USA). Two main approaches to health system change exist: incremental, gradual reform versus systemic, rapid development. Which takes place depends on many factors, including individuals (political leaders who are visionary and strong may be able to implement change more effectively), institutions (which may facilitate or obstruct rapid change), events (historically, many of the most dramatic changes have been associated with financial crises, wholesale political change, such as the collapse of communism, or national disasters), and national context (rapid change is much easier where political power is concentrated than where it is dispersed). Whether a country pursues gradual or rapid health system reforms and development is essentially a political rather than technical choice. Expansion of public health systems has been more common in the presence of governments sympathetic to labour and strong trade unions. While the political spectrum varies in different countries, in general, right-wing politicians have tended to favour gradual expansion of coverage, based on insurance, with measures aiming to de-radicalise opposition movements. Left-wing parties tend to view expansion of coverage as an expression of political ideology, as well as a means to secure support from their natural constituents. The process of debate that normally characterizes coalition governments tends to provide space for a wider range of actors, favouring social insurance, with gradual expansion. It also may provide more space for technical expertise to contribute to the design of reform.

## **AFFIRMATIVE EVIDENCE**

### *UNINSURED PEOPLE*

#### **MANY AMERICANS, EVEN THOSE IN THE MIDDLE CLASS, DO NOT HAVE SUFFICIENT HEALTH INSURANCE**

Kao-Ping Chua [AMSA Jack Rutledge Fellow 2005-2006] and Flávio Casoy [AMSA Jack Rutledge Fellow 2007-2008], "The Case for Universal Healthcare," AMSA, Web. (2008) Accessed 15 Oct. 2012. <<http://www.amsa.org/uhc/CaseForUHC.pdf>>.

Over the last few decades, the United States has witnessed skyrocketing health care costs. Health insurance premiums have been rising on average by double-digit percentage points over the past five years, a rate of increase that is 2-3 times the rate of inflation.<sup>1</sup> Because of these out-of-control health care costs, there has been a steep rise in the number of uninsured Americans. Currently, more than 45 million Americans lack any form of health insurance, and millions more are "underinsured" – they have insurance but lack adequate financial protection from health care costs.

While this problem was formerly a problem confined to low-income Americans, more and more middle-class citizens are becoming directly affected by the problem. In the face of rising health care costs, fewer employers are able to provide their workers with health insurance; the percentage of employers offering health insurance dropped from 69% in 2000 to 60% in 2005. Even if employers are able to provide health insurance benefits, the trend is towards providing high-deductible insurance that covers an ever-shrinking percentage of health care costs.<sup>1</sup> The net result is that more and more employed middle-class Americans find themselves with low-quality or no access to health care.

## **MEDICAID CAN ONLY PARTIALLY OFFSET THE LOSS OF EMPLOYER-BASED HEALTH INSURANCE**

Kao-Ping Chua [AMSA Jack Rutledge Fellow 2005-2006] and Flávio Casoy [AMSA Jack Rutledge Fellow 2007-2008], "The Case for Universal Healthcare," AMSA, Web. (2008) Accessed 15 Oct. 2012. <<http://www.amsa.org/uhc/CaseForUHC.pdf>>.

The erosion of employer-based coverage has been partially offset by increased enrollment in Medicaid, which is designed to provide a safety-net for the lowest income Americans.<sup>2</sup> However, Medicaid has recently been the subject of relentless funding cuts by cash-strapped states and Congressional representatives who are ideologically opposed to welfare programs. As the program continues to be slashed, it is certain that Medicaid will not be able to offset the losses in employer-based insurance, resulting in more and more uninsured individuals.

## **A VARIETY OF INDICATORS DEMONSTRATE THAT THE UNINSURED DO NOT RECEIVE NEEDED MEDICAL CARE AND HAVE MARKEDLY WORSE HEALTH OUTCOMES**

Kao-Ping Chua [AMSA Jack Rutledge Fellow 2005-2006] and Flávio Casoy [AMSA Jack Rutledge Fellow 2007-2008], "The Case for Universal Healthcare," AMSA, Web. (2008) Accessed 15 Oct. 2012. <<http://www.amsa.org/uhc/CaseForUHC.pdf>>.

The problems of accessing health care for the uninsured have been detailed extensively.<sup>4,5</sup>

- **The uninsured are less likely to be able to fill prescriptions and more likely to pay much more of their money out-of-pocket for prescriptions.** In a recent survey, one third of uninsured Americans reported that they were unable to fill a prescription drug in the last year because of the cost.
- **The uninsured are 3-4 times more likely than those with insurance to report problems getting needed medical care, even for serious conditions.** In one study, more than half of the uninsured postponed needed medical care due to financial concerns, while over one third went without a physician-recommended medical test or treatment due to financial concerns.
- **The uninsured are less likely to have a regular source of health care.** 40% of the uninsured do not have a regular place to go when they are sick or need medical advice, compared to less than 10% of the insured. As a result, 20% of the uninsured say their usual source of care is the emergency room, compared to just 3% of the insured.
- **The uninsured are less likely to get needed preventive care.** When compared to the insured, uninsured, non-elderly adults are 50% less likely to receive preventive care such as pap smears, mammograms, blood pressure checks, sigmoidoscopies, cholesterol screening, and prostate exams.
- **The uninsured are more likely to be forced to delay medical services, affecting the timeline of diagnosis and thus the prognosis of the disease process.** In one study, the time to diagnosis of late-stage cancer was compared between uninsured and privately insured patients. The uninsured patients were 1.7, 2.6, 1.4, and 1.5 times more likely to be diagnosed late for colorectal cancer, melanoma, breast cancer, and prostate cancer, respectively.
- **The uninsured are more likely to receive poor care for chronic diseases.** Among non-elderly adult diabetics, a lack of insurance is associated with less glucose monitoring and fewer foot and eye exams, leading to an increased risk of hospitalization and disability. Uninsured individuals with end-stage renal disease are more likely to have progressed to a more advanced stage before beginning dialysis.

As a result of these difficulties accessing health care, the non-partisan Institute of Medicine estimates that the uninsured have an excess annual mortality rate of 25%. This increased mortality translates into 18,000 excess deaths for people between age 25-64 per year, which is of comparable magnitude to the number of people in this age group who die each year from diabetes, stroke, HIV, and homicide.<sup>4</sup>

## **THE UNINSURED SUFFER EMOTIONALLY AND FINANCIALLY**

Kao-Ping Chua [AMSA Jack Rutledge Fellow 2005-2006] and Flávio Casoy [AMSA Jack Rutledge Fellow 2007-2008], "The Case for Universal Healthcare," AMSA, Web. (2008) Accessed 15 Oct. 2012. <<http://www.amsa.org/uhc/CaseForUHC.pdf>>.

The suffering caused by uninsurance goes far beyond the purely physical suffering experienced by uninsured individuals. Emotionally, uninsurance contributes to anxiety, familial stress, depression, and fear. Financially, medical costs are a major cause of personal bankruptcy. Even without bankruptcy, the financial strain on families can be significant and potentially ruinous.<sup>6</sup>

## **A LARGE NUMBER OF UNINSURED AMERICANS IS HARMFUL EVEN TO THOSE WHO DO HAVE INSURANCE**

Kao-Ping Chua [AMSA Jack Rutledge Fellow 2005-2006] and Flávio Casoy [AMSA Jack Rutledge Fellow 2007-2008], "The Case for Universal Healthcare," AMSA, Web. (2008) Accessed 15 Oct. 2012. <<http://www.amsa.org/uhc/CaseForUHC.pdf>>.

The consequences of America's decision to treat health care as a privilege extend far past the uninsured. With employers dropping health insurance at a record pace, more and more middle class Americans are at risk of uninsurance. Those who work for companies that continue to offer health insurance find themselves paying a higher share of health care costs than they did previously.<sup>1</sup> Finally, employees are finding their wage increases to be smaller and smaller as the cost of providing health insurance skyrockets for employers.

The most direct way in which the insured are affected by the lack of universal health care is illustrated by a 2005 study that surveyed people who filed for personal bankruptcy. In this study, 46.2% of those surveyed cited a medical cause for their bankruptcy. Of note, only 32.6% of those citing a medical cause of bankruptcy were uninsured at the time of filing, meaning that almost 7 out of 10 people in the survey were insured when they filed.<sup>7</sup> In other words, high medical bills and lost income due to illness can lead to bankruptcy even for the insured. A society that believes that people should pay a lot of money for the privilege of having health care is a society in which only the extraordinarily rich are truly immune to the threat of medical bankruptcy.



## **OBAMACARE DOES NOT GO FAR ENOUGH**

Stephanie Woolhandler [Prof., CUNY School of Public Health at Hunter College] and David Himmelstein [Prof., CUNY School of Public Health at Hunter College], "Healthcare Reform 2.0," *Social Research* Vol. 78 : No. 3 : (Fall 2011)

Obviously, our health system has grave problems requiring reform. These problems are epitomized by the unrelenting growth in the number of uninsured Americans over the past several decades. Our research group at Harvard published a study in 2009 showing that 45,000 Americans die annually due to lack of health insurance—about 1 death per 1,000 uninsured people (Wilper 2009: 2289–2295). That is not only an indictment of the current state of the health system, but also very worrisome in the context of the Obama reform. If Obama's plan works as hoped (that is, if everything goes right), it will still leave 24 million people uninsured when it is fully implemented in 2019, according to the Congressional Budget Office (CBO 2009). Twenty-four million uninsured Americans is simply unacceptable. Meanwhile, the safety-net hospitals on which these uninsured (and many underinsured) people will continue to rely will suffer a \$36 billion cut to help pay for the reform. On a brighter note, community health centers are slated to receive an extra \$1 billion annually due to an amendment submitted by the country's only socialist senator, Bernie Sanders of Vermont.

*DIRECT HEALTHCARE COSTS*

**THE PRIVATE HEALTH INSURANCE SYSTEM IN THE UNITED STATES DRIVES  
DRAMATICALLY HIGHER HEALTH CARE COSTS**

Ezekiel J. Emanuel [MD, PhD; Department of Bioethics, The Clinical Center, National Institutes of Health] and Victory R. Fuchs [Prof. Department of Economics, Stanford University], "The Perfect Storm of Overutilization," *JAMA*, Vol 299, No. 23 (June 18, 2008)

There are many explanations for the higher costs of US health care. Because health insurance must be underwritten and sold to individual employers and self-insured individuals, administrative costs exceed \$145 billion. This does not include employers' costs for purchasing and managing employees' health insurance. One estimate suggests that the private employer insurance market wastes more than \$50 billion in administrative costs.<sup>5</sup>

A second factor is higher prices in the United States for important inputs to health care, such as physicians' services, prescription drugs, and diagnostic testing. US physicians earn double the income of their peers in other industrialized countries (Table). Similarly, prices to the public for drugs in the United States are 10% to 30% higher than in other developed countries.<sup>6</sup> Disparities in prices of inputs to health care account for at least \$100 billion annually of higher spending in the United States.<sup>5</sup>

A third contributor to US costs is the abundance of amenities. Hospital rooms in the United States offer more privacy, comfort, and auxiliary services than do hospital rooms in most other countries. US physicians' offices are typically more conveniently located and have parking nearby and more attractive waiting rooms.

## THE COST OF ACHIEVING UNIVERSAL HEALTHCARE IS SIGNIFICANT BUT MANAGEABLE

Kao-Ping Chua [AMSA Jack Rutledge Fellow 2005-2006] and Flávio Casoy [AMSA Jack Rutledge Fellow 2007-2008], "The Case for Universal Healthcare," AMSA, Web. (2008) Accessed 15 Oct. 2012. <<http://www.amsa.org/uhc/CaseForUHC.pdf>>.

There a number of costs involved with achieving universal health care.<sup>8,9</sup>

- **The additional health care that would be used by the uninsured if they had insurance:**

The Institute of Medicine estimated that this would amount to \$34-\$69 billion per year, depending on whether the benefits package offered to the uninsured offered public insurance-level benefits (e.g. Medicaid or S-CHIP) or private insurance-level benefits. Note that this number assumes "no structural changes in the systems of health care financing or delivery, average scope of benefits, or provider payment".<sup>8</sup>

- **The cost of covering the out-of-pocket costs the uninsured currently pay:** The uninsured pay 35% of health care costs out-of-pocket, compared to 20% for the insured (8). It is estimated that of the \$100 billion in care the uninsured use per year, 26% was paid out-of-pocket by the uninsured, or \$26 billion. As Uwe Reinhardt wrote, "If the purpose of public policy in this area were to protect American families from financial distress, then presumably some of this out-of-pocket spending by the uninsured would be shifted from the uninsured to the government's budget".<sup>9</sup> The cost of covering these out-of-pocket costs would depend on the generosity of the benefits offered to the uninsured.

- **The cost of covering uncompensated care costs provided by hospitals, physicians, and other providers to the uninsured:** Currently, \$34.5 billion a year is spent on uncompensated care costs, which includes free care, discounted care, and "bad debt" that is written off by the provider if the uninsured person cannot pay.<sup>8</sup> A system that covered the uninsured would likely cover some or all of these uncompensated costs; the exact amount would depend on the specific solution in question.

- Finally, depending on the solution chosen, those who are currently privately insured may also use more health care (e.g. if health care were made available for all with no or minimal cost-sharing, there might be increased usage of health care across the board). Furthermore, there is the possibility that covering the uninsured through a public insurance program may tempt employers to drop coverage and push their employees onto the public insurance program ("crowd-out"); the exact magnitude of this additional cost would depend on the solution chosen.<sup>9</sup>

In summary, the cost of universal health care would be at least \$34-\$69 billion, plus whatever costs are associated with covering out-of-pocket expenses and uncompensated care for the uninsured. Specific solutions may entail additional expenses as well, depending on their design parameters.

## UNIVERSAL HEALTHCARE SYSTEMS COMBINED WITH COST CONTROL MEASURES CAN REDUCE OVERALL COSTS TO THE SYSTEM IN A RELATIVELY SHORT TIME

Kao-Ping Chua [AMSA Jack Rutledge Fellow 2005-2006] and Flávio Casoy [AMSA Jack Rutledge Fellow 2007-2008], "The Case for Universal Healthcare," AMSA, Web. (2008) Accessed 15 Oct. 2012. <<http://www.amsa.org/uhc/CaseForUHC.pdf>>.

In 2005, the Emory economist Dr. Kenneth Thorpe published an important report for the National Coalition for Health Care, a strictly non-partisan, broad-based coalition of businesses, providers, unions, and other groups interested in improving the health care system. In this report, Dr. Thorpe calculated the costs to the government of instituting health care for all under four different scenarios:

- Institute an employer mandate plus individual mandate (requiring employers to provide a certain level of health benefits, and requiring individuals who do not get employer-based insurance to obtain health insurance through some mechanism)
- Expand public programs such as Medicaid;
- Create a new program for the uninsured modeled after the Federal Employee Health Benefits Plan (FEHBP), the insurance plan for federal employees;
- Create a universal, public financed plan.

This study did not just focus on expanding access; it also assumed significant systemic changes including administrative simplification, computerized physician order entry, an automated patient safety/error reporting system, reduction in inappropriate clinical practice variation, and controls of provider payments and premiums to reach target goals in expenditure growth. According to Thorpe's analysis, each of these four options would save money over 10 years. The first two options would save \$320.5 billion over 10 years, the third option would save \$369.8 billion over 10 years, and the fourth option would save \$1.1 trillion over 10 years.<sup>16</sup>

The important point to take away from Thorpe's study is that universal health care, **coupled with cost controls**, can save money while expanding health care access to everyone. If universal health care simply expanded access, the net expenditure would be large. The only way to pay for this expanded access is to institute cost controls such as administrative simplification.

Note that it is much easier in some universal health care solutions to institute cost controls than others. For instance, a single payer system allows for a more dramatic reduction of administrative costs than do the other three solutions, all of which build on the current system.

*INDIRECT HEALTHCARE COSTS*

**THERE ARE ENORMOUS HIDDEN COSTS TO A HIGH UNINSURANCE RATE**

Kao-Ping Chua [AMSA Jack Rutledge Fellow 2005-2006] and Flávio Casoy [AMSA Jack Rutledge Fellow 2007-2008], "The Case for Universal Healthcare," AMSA, Web. (2008) Accessed 15 Oct. 2012. <<http://www.amsa.org/uhc/CaseForUHC.pdf>>.

What are the costs of not achieving universal health care?

In a landmark six-part series on the uninsured, the Institute of Medicine compiled an extensive report on the "hidden" costs of uninsurance.<sup>8</sup>

- **Fewer years of participation in the workforce:** The annual cost of diminished health and shorter life spans of Americans without insurance is \$65-\$130 billion. People who do not live as long do not work and contribute to the economy as long.
- **Developmental losses for children:** children who are uninsured are more likely to suffer delays in development because of poor health, thus affecting their future earning capacity.
- **Cost to public programs:** Medicare, Social Security Disability Insurance (SSDI), and the criminal justice system have higher costs than they would if there were universal coverage. For Medicare, the reason is that people who are uninsured have poorer health, and this poorer health translates into higher expenses once they become enrolled in Medicare. A similar effect exists for SSDI and the criminal justice system, although to a smaller degree because most people do not end up using these programs whereas the vast majority ultimately enroll in Medicare at age 65.

## HIGH LEVELS OF UNINSURED CITIZENS ARE VERY COSTLY TO COMMUNITIES

Kao-Ping Chua [AMSA Jack Rutledge Fellow 2005-2006] and Flávio Casoy [AMSA Jack Rutledge Fellow 2007-2008], "The Case for Universal Healthcare," AMSA, Web. (2008) Accessed 15 Oct. 2012. <<http://www.amsa.org/uhc/CaseForUHC.pdf>>.

The Institute of Medicine also studied the cost of high rates of uninsurance to communities.<sup>10</sup>

- **Lower health care delivery capacity:** Communities with high levels of uninsurance tend to have a lower health care delivery capacity, as providers burdened by the costs of uncompensated care reduce staff, relocate, or close.
- **Impaired access to emergency departments:** Access to ER's is impaired for both uninsured and insured individuals in communities with high rates of uninsurance. The reason is twofold: emergency departments burdened by uncompensated care costs close down or reduce capacity, and uninsured individuals who have nowhere else to turn to for primary care overcrowd ER's.
- **Weakened local economy:** A high rate of uninsurance and the corresponding burden of uncompensated care costs weakens a community's health infrastructure (e.g. closing or downsizing of local hospitals). Since health care is an important part of a community's economic base, communities suffer economically.
- **Adverse effects on public health:** Communities with high rates of uninsurance have less effective control of communicable disease (e.g. less vaccinations, less surveillance of TB) and an overall greater disease burden in general. Furthermore, public health agencies may have budgetary problems if the local government has to siphon dollars away to pay for safety net services for the uninsured.

## WIDESPREAD UNINSURANCE CREATES ECONOMIC INEFFICIENCY

Kao-Ping Chua [AMSA Jack Rutledge Fellow 2005-2006] and Flávio Casoy [AMSA Jack Rutledge Fellow 2007-2008], "The Case for Universal Healthcare," AMSA, Web. (2008) Accessed 15 Oct. 2012. <<http://www.amsa.org/uhc/CaseForUHC.pdf>>.

In addition to the costs delineated by the Institute of Medicine, there are several other areas of economic inefficiency because of the lack of universal health care in America:

- **Unnecessary use of the ER:** the ER is an expensive place to receive care. An average visit to an emergency room costs \$383.11 whereas the average physician's office visit costs \$60.12 It is estimated that 10.7% of ER visits in 2000 were for non-emergencies, costing the system billions of dollars.<sup>13</sup>
- **Lack of preventive care and adequate care of chronic diseases:** Because the uninsured do not get the preventive and chronic disease care they need, they are more likely to develop complications and advanced stage disease, both of which are expensive to treat. The magnitude of this cost is difficult to estimate, but it is significant.
- **"Job lock":** Job lock refers to the idea that people stay with their jobs when they would rather work elsewhere because their current job offers health insurance. For example, many individuals opt to stay with their job instead of starting their own business because they are unsure of whether they can get health insurance on the individual market, which has higher premiums and often denies people with pre-existing conditions. Although the number of people who would be self-employed if there were universal health care is controversial, one study from 2001 put the number at 3.8 million Americans.<sup>14</sup> This loss of entrepreneurship is a real economic cost in a society that is relying on start-ups to offset the loss of jobs that are moving offshore.

**THE ADVANTAGES OF UNIVERSAL COVERAGE ACCRUE TO EVERYONE, NOT JUST INDIVIDUALS WHO USE THEIR INSURANCE**

Dale Murray [Prof. of Philosophy, University of Wisconsin-Baraboo], "The Massachusetts Health Plan, Individual Mandates, and the Neutrality of the Liberal State," *Journal of Medicine and Philosophy*, 36: 466–483, (2011)

Major advantages from universal or near-universal coverage of the population accrue to virtually everyone. In regard to efficiency, these include more accessible preventive care, lower inappropriate use of emergency rooms (which operate as providers of last resort for the uninsured), freedom from financial and care-giving burdens placed on others by the uninsured, and lower absenteeism and more reliable productivity from a workforce that can access basic health services. In regard to justice, these advantages include the presence of well and ill alike in a common pool for sharing the costs of care, so that no one finds fair equality of opportunity in life blocked by the direct expense of illness or insurance. This avoids situations where people fail to pay into insurance pools because they believe they are well enough not to need insurance, only to have to be bailed out by others who end up providing them significant care.



## **MANY BANKRUPTCIES ARE CAUSED BY HEALTH DEBT**

Stephanie Woolhandler [Prof., CUNY School of Public Health at Hunter College] and David Himmelstein [Prof., CUNY School of Public Health at Hunter College], "Healthcare Reform 2.0," *Social Research* Vol. 78: No. 3 : (Fall 2011)

The problems in US health care finance are not restricted to the uninsured; our fragmented, inadequate payment system causes tremendous suffering among insured Americans as well. Research we undertook with colleagues at Harvard Law School and Ohio University found that more than half of all US bankruptcies are due, at least in part, to medical illness or medical bills (Himmelstein and Warren 2005; Himmelstein and Thorne 2009: 741–746). This headline from our study was widely cited in the 2009–2010 health reform debate. But another of our findings received much less attention—in the overwhelming majority of medical bankruptcies, the patient had health insurance, at least when they first got sick. In our most recent data on bankruptcy filers in 2007, 78 percent of those whose illness caused a medical bankruptcy had health insurance. In some cases patients started the illness with insurance, only to lose it along with their job after they became sick. In many more cases, people had insurance—usually private health insurance—which they held on to throughout the bankrupting illness. Yet they were bankrupted anyway by gaps in their coverage, like copayments, deductibles, and uncovered services.

*DISTRIBUTIVE JUSTICE*

**HEALTHCARE SERVICES ARE ESPECIALLY SIGNIFICANT IN QUESTIONS OF DISTRIBUTIVE JUSTICE BECAUSE HEALTH AFFECTS OUR RANGE OF OPPORTUNITIES IN SOCIAL LIFE**

Norman Daniels [Professor of Population Ethics and Professor of Ethics and Population Health, Harvard School of Public Health] (2001): Justice, Health, and Healthcare, *The American Journal of Bioethics*, 1:2, 2-16

The central moral importance, for purposes of justice, of preventing and treating disease and disability with effective healthcare services (construed broadly to include public health and environmental measures, as well as personal medical services) derives from the way in which protecting normal functioning contributes to protecting opportunity. 1 Specifically, by keeping people close to normal functioning, healthcare preserves for people the ability to participate in the political, social, and economic life of their society. It sustains them as fully participating citizens—normal collaborators and competitors—in all spheres of social life.

By maintaining normal functioning, healthcare protects an individual's fair share of the normal range of opportunities (or plans of life) reasonable people would choose in a given society. This normal opportunity range is societally relative, dependent on various facts about the society's level of technological development and social organization. Individuals' fair shares of that societal normal opportunity range are the plans of life it would be reasonable for them to choose were they not ill or disabled and were their talents and skills suitably protected against mis- or underdevelopment as a result of unfair social practices and the consequences of socioeconomic inequalities. Individuals generally choose to develop only some of their talents and skills, effectively narrowing their range of opportunities. Maintaining normal functioning preserves, however, their broader, fair share of the normal opportunity range, giving them the chance to revise their plans of life over time.

**ANY HEALTHCARE SYSTEM DESIGNED TO ADDRESS EQUALITY OF OPPORTUNITY  
MUST BE UNIVERSAL AND BE ABLE TO RATION LIMITED RESOURCES FAIRLY**

Norman Daniels [Professor of Population Ethics and Professor of Ethics and Population Health, Harvard School of Public Health] (2001): Justice, Health, and Healthcare, *The American Journal of Bioethics*, 1:2, 2-16

The account sketched here has several implications for the design of our healthcare institutions and for issues of resource allocation. Perhaps most important, the account supports the provision of universal access to appropriate healthcare—including traditional public health and preventive measures— through public or mixed public and private insurance schemes. Healthcare aimed at protecting fair equality of opportunity should not be distributed according to ability to pay, and the burden of payment should not fall disproportionately on the ill (Daniels 1985, 1995; and Daniels, Light, and Caplan 1996).

Properly designed universal coverage health systems will be constrained by reasonable budgets, since healthcare is not the only important good. Reasonable resource constraints will then require judgments about which medical needs are more important to meet than others. Priority setting and rationing is thus a requirement of justice, since meeting healthcare needs should not and need not be a bottomless pit.

## RELATIVE ECONOMIC INEQUALITY IS AN IMPORTANT FACTOR IN DETERMINING HEALTH OUTCOMES

Norman Daniels [Professor of Population Ethics and Professor of Ethics and Population Health, Harvard School of Public Health] (2001): Justice, Health, and Healthcare, *The American Journal of Bioethics*, 1:2, 2-16

One especially important factor in explaining the health of a society is the distribution of income: the health of a population depends not just on the size of the economic pie, but also on how the pie is shared. Differences in health outcomes among developed nations cannot be explained simply by the absolute deprivation associated with low economic development—lack of access to the basic material conditions necessary for health, such as clean water, adequate nutrition and housing, and general sanitary living conditions. The degree of relative deprivation within a society also matters.

Numerous studies support this *relative-income hypothesis*, which states, more precisely, that inequality is strongly associated with population mortality and life expectancy across nations (Wilkinson 1992, 1994, 1996). Rich countries vary in life expectancy, and that variation dovetails with income distribution. In particular, wealthier countries with more equal income distributions, such as Sweden and Japan, have higher life expectancies than the United States, despite having lower per capita GDP. Likewise, countries with low GDPpc but remarkably high life expectancy, such as Costa Rica, tend to have a more equitable distribution of income.

We find a similar pattern when we compare states within the United States. If we control for differences in state wealth, income inequality accounts for about 25% of the between-state variation in age-adjusted mortality rates (Kennedy, Kawachi, and Prothow-Stith 1996; Kawachi et al. 1997). Furthermore, a recent study across U.S. metropolitan areas found that areas with high income inequality had an excess of death compared to areas with low inequality—a very large excess, equivalent in magnitude to all deaths due to heart disease (Lynch et al. 1998). Longitudinal studies, which look at a single place over time and examine widening income differentials, support similar conclusions.

At the individual level we also find that inequality is important. Numerous studies have documented what has come to be known as the socioeconomic gradient: At each step along the economic ladder, we see improved health outcomes over the rung below (even in societies with universal health insurance). Differences in health outcomes are not confined to the extremes of rich and poor, but are observed across all levels of socioeconomic status.

## INVESTMENT IN HUMAN CAPITAL IS A STRONG PREDICTOR OF HEALTH

Norman Daniels [Professor of Population Ethics and Professor of Ethics and Population Health, Harvard School of Public Health] (2001): Justice, Health, and Healthcare, *The American Journal of Bioethics*, 1:2, 2-16

When we compare countries, we also find that differential investment in human capital—in particular, education—is a strong predictor of health. Indeed, one of the strongest predictors of life expectancy among developing countries is adult literacy, particularly the disparity between male and female adult literacy, which explains much of the variation in health achievement among these countries after accounting for GDPpc. For example, among the 125 developing countries with GDPpc of less than \$10,000, the difference between male and female literacy accounts for 40% of the variation in life expectancy (after factoring out the effect of GDPpc). In the United States differences among the states in women's status—measured in terms of economic autonomy and political participation—are strongly correlated with higher female mortality rates.

## TO BE JUST, HEALTHCARE RATIONING DECISIONS MUST MEET FOUR CONDITIONS

Norman Daniels [Professor of Population Ethics and Professor of Ethics and Population Health, Harvard School of Public Health] (2001): Justice, Health, and Healthcare, *The American Journal of Bioethics*, 1:2, 2-16

We would take a giant step toward solving the problems of legitimacy and fairness that face public agencies and private health plans making limit-setting decisions if the following four conditions were satisfied (Daniels and Sabin 1997):<sup>7</sup>

**Publicity Condition:** Decisions regarding coverage for new technologies (and other limit-setting decisions) and their rationales must be publicly accessible.

**Relevance Condition:** The rationales for coverage decisions should aim to provide a reasonable construal of how the organization (or society) should provide “value for money” in meeting the varied health needs of a defined population under reasonable resource constraints. Specifically, a construal will be “reasonable” if it appeals to reasons and principles that are accepted as relevant by people who are disposed to finding terms of cooperation that are mutually justifiable.

**Appeals Condition:** There is a mechanism for challenge and dispute resolution regarding limit-setting decisions, including the opportunity for revising decisions in light of further evidence or arguments.

**Enforcement Condition:** There is either voluntary or public regulation of the process to ensure that conditions 1–3 are met.

The guiding idea behind the four conditions is to convert private health plan or public agency decisions into part of a larger public deliberation about how to use limited resources to protect fairly the health of a population with varied needs. The broader public deliberation envisioned here is not necessarily an organized democratic procedure, though it could include the deliberation underlying public regulation of the healthcare system. Rather, it may take place in various forms in an array of institutions, spilling over into legislative politics only under some circumstances. Meeting these conditions also serves an educative function. The public is made familiar with the need for limits and appropriate ways to reason about them.

## **IT IS DIFFICULT FOR PRIVATE INSURANCE FIRMS TO JUSTLY DENY COVERAGE ON THE BASIS OF COST**

Norman Daniels [Professor of Population Ethics and Professor of Ethics and Population Health, Harvard School of Public Health] (2001): Justice, Health, and Healthcare, *The American Journal of Bioethics*, 1:2, 2-16

How should we view the claim that a treatment “costs too much”? First, suppose this is a claim about relative cost-effectiveness or worthiness. People who share in the goal of meeting the varied medical needs of a population covered by limited resources would consider relevant the claim that a particular technology falls below some defensible threshold of cost-effectiveness or relative cost-worthiness. Suppose, however, the claim that something “costs too much” refers to its effects on profits or competitiveness. Supporting this claim often requires providing information that private health plans will not reveal (for good business reasons), often turns on economic and strategic judgments requiring special experience and training, and ultimately depends on a much more fundamental claim about the design of the system, namely, that a system involving competition in this sort of market will produce efficiencies that work to the advantage of all who have medical needs. My point is not that these reasons fail to meet the Relevance Condition, but that providing support for them requires information that is often not available, that is hard to understand when it is available, and that ultimately depends on fundamental moral and political judgments about the feasibility of quite different alternative systems for delivering healthcare. Nevertheless, if for-profit health plans are to comply with the Relevance Condition, they must either be willing to provide information they would ordinarily not make public, or make their decisions on the basis of reasons that they can defend to other relevant stakeholders.

## UNEQUAL ACCESS TO HEALTHCARE INDICATES A LACK OF EQUAL RESPECT

Amy Guttmann [Professor of Political Science, Communications, and Philosophy, University of Pennsylvania], "For and Against Equal Access to Healthcare," *The Milbank Memorial Fund Quarterly. Health and Society*, Vol. 59, No. 4 (1981), pp.542-560

Some of the conditions necessary for equal respect are socially relative; we must arrive at a standard of equal respect appropriate to our particular society. Universal suffrage has long been a condition for equal respect; the case for it is independent of the anticipated results of equalizing political power by granting every person one vote. More recently, equal access to health care has similarly become a condition for equal respect in our society. Most of us do not base our self-respect on the way we are treated on airplanes, even though the flight attendants regularly give preferential treatment to those traveling first class. This contrast with suffrage and health care treatment (and education and police protection) no doubt is related to the fact that these goods are much more essential to our security and opportunities in life than is airplane travel. But it is still worth considering that unequal treatment in health care, as in education, may be understood as a sign of unequal respect even where there are no discernible adverse effects on the health or education of those receiving less favored treatment. Even where a dual health care system will not produce inferior medical results for the less privileged, the value of equal respect militates against the perpetuation of such a system in our society.



**SIMPLY PROVIDING EVERYONE WITH A BASIC MINIMUM INCOME IS INSUFFICIENT TO PROVIDE HEALTHCARE COVERAGE**

Amy Guttman [Professor of Political Science, Communications, and Philosophy, University of Pennsylvania], "For and Against Equal Access to Healthcare," *The Milbank Memorial Fund Quarterly. Health and Society*, Vol. 59, No. 4 (1981), pp.542-560

Although a minimum income floor under all individuals increases access to most goods and services, even at a higher level than that supported by Friedman and others, a guaranteed income will be inadequate to sustain the costs of a catastrophic illness. An exceptionally high guaranteed minimum might result in almost universal insurance coverage at a fairly high level. Supporters of free market allocation do not, however, press for a very high minimum for at least two reasons. They fear its effects on incentives, and they cannot justify a high guaranteed income without admitting that there are many expensive goods that are essential to all persons, and are not just mere consumer preferences.

**UNIVERSAL HEALTH CARE IS MORE EQUITABLE AND EFFECTIVE.**

Stuckler, David [University of Oxford, UK; London School of Hygiene and Tropical Medicine, UK], Andrea B. Feigl [Harvard School of Public Health, USA], Sanjay Basu [University of California San Francisco, USA], and Martin McKee [London School of Hygiene and Tropical Medicine, UK]. "The Political Economy of Universal Health Coverage," *Background paper for the Global Symposium on Health Systems Research*. November 16-19, 2010.

Most countries have adopted legal commitments to achieve Universal Health Coverage at low- and middle-income stages of development. When they have not, healthcare has tended to expand gradually, leaving many members of the population vulnerable for extended periods of time. However, a legal commitment is insufficient on its own and must be translated into policies that establish a comprehensive, largely publicly financed system. An over-reliance on partial and private sector-focused care appears to disproportionately benefit richer groups, reducing both efficacy and access to coverage. It also creates groups with strong vested interests in the status quo that can block further progress. Public financing is more equitable and pro-poor, and reflects the shared value of providing care based on need rather than ability to pay.

**RIGHTS PERSPECTIVE TO HEALTHCARE ACCOUNTS FOR THE FACT THAT SOCIAL DETERMINANTS ARE FUNDAMENTAL CAUSES OF DISEASE.**

Alicia Ely Yamin, JD, MPH [Harvard School of Public Health; human rights attorney who at the time of writing was working with nongovernmental organizations in Latin America]. "The Right to Health Under International Law and Its Relevance to the United States," American Journal of Public Health, July 2005, Vol 95, No. 7.

Under international law, there is a right not merely to health care but to the much broader concept of health. Because rights must be realized inherently within the social sphere, this formulation immediately suggests that determinants of health and ill health are not purely biological or "natural" but are also factors of societal relations.<sup>1,2</sup> Thus, a rights perspective is entirely compatible with work in epidemiology that has established social determinants as fundamental causes of disease.<sup>3–6</sup>

**RIGHT TO HEALTH HAS BASIS IN SOCIAL JUSTICE AND UTILITARIAN VIEWS.**

Engelhard, Carolyn L. [MPA], Garson, Arthur Jr. [MD, MPH]. "The Right to Health Care and the Role of Government in Health Policy," Miller Center of Public Affairs, University of Virginia. February 28, 2008.

<<http://www.medicine.virginia.edu/clinical/departments/phs/news/docs/mcbriefingfinal.pdf>>

The belief in a right to health care has its basis in two moral principles: 1) the "social justice" argument that health care maintains an individual's normal functioning and therefore preserves the ability to participate in the social and economic life of society; and 2) the "utilitarian" view that guaranteeing health services increases the welfare of the greatest number of people.<sup>4</sup> The first principle is advanced by John Rawls who argued that a just society would guarantee personal freedoms as long as they did not limit the freedom of others and would promote equality of opportunity. The social justice model benefits the least advantaged in society because it advocates keeping people close to normal functioning in order to allow them a "fair share" in the full participation in society. Viewed in this way, access to health, broadly speaking, and by extension, to health services, preserves for people the ability to participate in the political, social, and economic life of their society.<sup>5</sup>

*HUMAN DIGNITY, AUTONOMY, AND COMMUNITY*

**UNIVERSAL HEALTHCARE HAS A MORAL FOUNDATION IN RESPECT FOR HUMAN DIGNITY.**

Lawrence D. Brown [Professor of Health Policy and Management, Mailman School of Public Health, Columbia University]. "Comparing Health Systems in Four Countries: Lessons for the United States," American Journal of Public Health, January 2003, Vol 93, No. 1.

All 4 nations entitle almost all their citizens to health coverage. Health care is not enough; their images of solidarity, community, and equity insist that how care is obtained, not merely that it be somehow obtainable, matters greatly. Respect for human dignity demands that no one refrain from seeking medical care from fear of the consequences of doing so, and that no one suffer financial adversity as a result of having sought care. The moral foundations of universal coverage are as simple as that.

**EQUAL ACCESS TO HEALTHCARE ACTUALLY EXPANDS FREEDOM BY BOTH  
PROTECTING HEALTH AND RESPECTING THE RIGHT OF THE POLITY TO SHAPE ITS  
OWN POLICIES**

Amy Gutman [Professor of Political Science, Communications, and Philosophy, University of Pennsylvania], "For and Against Equal Access to Healthcare," *The Milbank Memorial Fund Quarterly. Health and Society*, Vol. 59, No. 4 (1981), pp.542-560

Would an equal access system necessarily be intrusive or paternalistic in its operation? A national health care system simply cannot be said to take away the income entitlement of citizens, since citizens are not entitled to their gross incomes. We can determine our income entitlements only after we deduct from our gross income the amount we owe the state to support the rights of others. To the extent that the rationale of an equal access principle is redistributive, those individuals who otherwise could not afford certain health care services will experience an expansion of their freedom (if we assume an adequate level of social provision). Of course, part of the justification of a national health care system is that it would also guarantee health care coverage to people who could afford adequate health care but who would not be prudent enough to save or to invest in insurance. Even if we accept the common definition of paternalistic actions as those that restrict an individual's liberty so as to further his or her interest, we still have to assess the assertion that this (partial) rationale for an equal access system entails a restriction of individual liberty. Unlike a law banning the sale of cigarettes or forcing people to wear seat belts, the institution of a national health care system forces no one to use it. If a majority of citizens decide that they want to be taxed in order to ensure health care for themselves, the resulting legislation could not be considered paternalistic: "Legislation requiring contributions to some cooperative scheme (such as medical care) . . . is not necessarily paternalistic, so long as its purpose is to give effect to the desires of a democratic majority, rather than simply to coerce a minority who do not want the benefits of the legislation" (Thompson, 1980:247). It is significant in this regard that for the past twenty years the Michigan survey of registered voters has found a consistent and solid majority supporting government measures designed to ensure universal access to medical care.

**TO CLAIM THAT EQUAL ACCESS TO HEALTHCARE IS PATERNALISTIC WOULD  
REQUIRE SAYING THAT ALL PROGRAMS DESIGNED TO PROTECT SOCIETY'S  
INTERESTS ARE PATERNALISTIC**

Amy Guttmann [Professor of Political Science, Communications, and Philosophy, University of Pennsylvania], "For and Against Equal Access to Healthcare," *The Milbank Memorial Fund Quarterly. Health and Society*, Vol. 59, No. 4 (1981), pp.542-560

The charge of paternalism levied against an equal access system is therefore dubious because it is extremely difficult, if not impossible, to isolate the self-protectionist rationale from the redistributive and the democratic rationales. Those who object to a national health care system on the grounds that it is coercing some people for their own good forget that such a system still could be justified as a means to avoid the threat to a one-class system that exempting the rich would create. To condemn such a system as paternalistic would commit us to criticizing all legislation in which a democratic majority decides to protect itself against the wishes of a minority when exemption from the resulting policy would undermine it. Other critics wrongly assume that people have an entitlement to the cash equivalent of the medical care to which society grants them a right. People do not have such an entitlement because taxpayers have a right to demand that their tax dollars are spent to satisfy health needs, not to buy luxuries. Indeed, our duty to pay taxes is dependent upon the fact that certain needs of other people must be given priority over our own desires for more commodious living.

## **HEALTHCARE REFORM HAS BEEN UNDERMINED BY PRIVATE FIRMS CORRUPTING THE POLITICAL PROCESS**

Stephanie Woolhandler [Prof., Cuny School of Public Health at Hunter College] and David Himmelstein [Prof., Cuny School of Public Health at Hunter College], "Healthcare Reform 2.0," *Social Research* Vol. 78 : No. 3 : (Fall 2011)

What role did the health industry play in the Obama health reform? Insurance firms donated hundreds of millions of dollars to Democrats as well as to Republicans. They then donated another \$100 million dollars to an ad campaign opposing the bill. So while the Democrats embraced the centrist mandate-style reform (a reform first proposed by President Richard Nixon in an effort to block Senator Ted Kennedy's single-payer bill in 1971), the advertising campaign (which appeared under the name of the US Chamber of Commerce but was actually paid for by the insurance industry) opposed it from the right. The insurance industry's funding of both the right and center of the reform debate was aimed at shutting out voices to the left of the administration. Meanwhile, the Pharmaceutical Manufacturers of America (PharMA) donated more than \$100 million to a campaign supporting reform, which promises to expand the market for their products, while eschewing price controls. The Senate framework on which President Barack Obama's reform was based was written by Liz Fowler, the former vice president for public policy for Wellpoint/Anthem, the nation's largest private insurer.



**FAILURE TO PURSUE UNIVERSAL HEALTHCARE IN THE U.S. IS A REFLECTION OF A LACK OF STRONG COMMUNITY SOLIDARITY.**

Lawrence D. Brown [Professor of Health Policy and Management, Mailman School of Public Health, Columbia University]. "Comparing Health Systems in Four Countries: Lessons for the United States," American Journal of Public Health, January 2003, Vol 93, No. 1.

The moral and cultural foundations of universal coverage are missing in the United States, as the continuing presence of 40 million uninsured would seem to intimate. Circumstances are not propitious: 85% of the population has medical coverage, much of it funded by private employers; the 15% who lack insurance are not organized, cohesive, or politically active; sizable redistributive shifts by national design are not the political system's strongest suit; and the right-of-center precincts in which that system has lingered for the past 35 years do nothing to ease the struggle. Equally important, Americans "know" that safety net providers care for people who lack coverage—a powerful inhibition to public action in a nation whose welfare state programs aim less at broad-ranging security in health and other policy spheres than at post factum compensation for those who fall through private-sector cracks. Reformist appeals based on human dignity (to which health security is fundamental) resonate very little here. September 11 and rescued miners aside, solidarity finds little place in the national political lexicon. Likewise, in the United States, community is not a spur to national action but rather an alternative to—and an excuse for—declining to pursue it. The brightest and best strategies to build a normative case for universal coverage have failed so far, and no one seems to know how to change these values, which are, by definition, fairly durable.

**DISCRIMINATORY ACCESS TO HEALTH CARE IS NOT JUST A HEALTH ISSUE – IT’S A DEMOCRACY ISSUE.**

Alicia Ely Yamin, JD, MPH [Harvard School of Public Health; human rights attorney who at the time of writing was working with nongovernmental organizations in Latin America]. “The Right to Health Under International Law and Its Relevance to the United States,” American Journal of Public Health, July 2005, Vol 95, No. 7.

Discrimination affects multiple social determinants of health in the United States, as well as treatment, and minorities are far more likely to lack access to care than Whites; this demonstrates that discrimination within the health care system must be understood and addressed within the broader society, not just as a health issue but as a democracy issue.<sup>67</sup> For example, in his report on his site visit to the United States in 1994, the UN Special Rapporteur on Contemporary Forms of Racism, Racial Discrimination, Xenophobia and Related Intolerance (Special Rapporteur) noted not only the manifold consequences of racism and racial discrimination in the field of health but also referred to the responsibility of the US government for “sociological inertia, structural obstacles and individual resistance hindering the emergence of a truly integrated society based on the equal dignity of the members of the American nation.”<sup>68</sup>(¶112)

*SOCIAL CONTRACT AND RIGHT TO HEALTHCARE*

**THE LOCKEAN CONCERN FOR LIFE, LIBERTY, AND PROPERTY REQUIRES THE  
GUARANTEE OF UNIVERSAL HEALTHCARE**

Daniel M. Hausman [Prof. of Philosophy, University of Wisconsin – Madison], “A LOCKEAN ARGUMENT FOR UNIVERSAL ACCESS TO HEALTH CARE,” *Social Philosophy and Policy*, Volume 28, Issue 2 (May 2011), pp 166-191

Because the Lockean's central goals of government are the protection of life, property, and freedom, government has a role in addressing threats to life, property, and freedom when it is difficult or socially costly for individuals to protect themselves. Unlike those who read Locke as insisting that government only protect rights, I take Locke to be concerned with the whole gamut of threats to life, property, and freedom. Crime, ignorance, malnutrition, tyrannical or bloated government, badly defined or poorly enforced property rights, foreign invasion, and disease all limit life expectancy or freedom. Individuals can and should cope with some of these threats themselves. But if individuals cannot protect themselves and government action is not itself a greater threat than the problem it aims to tackle, then government should act. If (1) health care and public health measures are effective ways of addressing the threats that disease poses to lives and freedom, (2) these measures do not themselves threaten freedom, and (3) individuals cannot provide their own health care, then government has a responsibility to insure that health care is available.<sup>32</sup> “That equal right, that every man hath, to his natural freedom”<sup>33</sup> implies that health care should be available to all.

**THE LOCKEAN JUSTIFICATION FOR UNIVERSAL HEALTHCARE IS PREFERABLE TO ONE BASED ON DISTRIBUTIVE JUSTICE BECAUSE IT IS CONCERNED WITH FREEDOM, LIFE AND PROPERTY RATHER THAN EQUALITY OF DISTRIBUTION**

Daniel M. Hausman [Prof. of Philosophy, University of Wisconsin – Madison], “A LOCKEAN ARGUMENT FOR UNIVERSAL ACCESS TO HEALTH CARE,” *Social Philosophy and Policy*, Volume 28, Issue 2 (May 2011), pp 166-191

The Lockean position is concerned with the protection of life, property, and self-determination rather than equality of anything, and it consequently avoids many of these problems. What is crucial are the ways in which diminished health threatens life and self-determination, not how the threats to different individuals or their life-prospects compare. The fact that the effects of diminished health on self-determination are sensitive to social factors does not threaten the case for universal access, but rather reinforces it. For example, Franklin Roosevelt’s paraplegia did not prevent him from shaping his own life (and, indeed, the lives of millions of others), but had he not been a man of means, his condition would have limited his independence and his ability to pursue his own life-plan. Technological and personal assistance to those without FDR’s wealth can go a long way toward enhancing their freedom. Public health measures, coupled with guaranteed universal access to basic health care, will expand the independence and self-determination of those whose social situations magnify limitations on freedom that are due to health deficiencies.

## THE INDIVIDUAL MANDATE DOES NOT VIOLATE THE NEUTRALITY REQUIREMENT OF A LIBERAL STATE

Dale Murray [Prof. of Philosophy, University of Wisconsin-Baraboo], "The Massachusetts Health Plan, Individual Mandates, and the Neutrality of the Liberal State," *Journal of Medicine and Philosophy*, 36: 466–483, (2011)

On the face of things, state neutrality is not really tenable. Obviously, the liberal state cannot be neutral in the selection of social policies. First of all, equal rights, at least in a very formal sense, is defended by all liberals on the grounds that we ought to have respect for persons. This is as true for libertarians as it is for liberal egalitarians. In fact, this is how Nozick and Rawls have a shared grounding in Kantian moral theory. But notice that equality and respect for persons are not value-neutral. There are very strong reasons for thinking that both principles are important, so significant in fact that we would want to admit that they are social values and defend them on a moral basis.

Notice as well that strict requirements on governments to be neutral in the face of a decision to make social policy would not allow governments to act at all. The reasons that even liberal states give for selecting certain social policies are based on substantive moral positions. This is reflected in the definite legal positions the state takes when deciding the laws citizens are expected to follow. In sum, no laws would exist if state neutrality were true. On top of this, if the state remained neutral with respect to all moral issues, this would in fact be an immoral position. We expect that in the face of deep moral controversies, the state will present detailed justifications of why laws are endorsed or interpreted in certain ways. But these reasons will inevitably be based upon some sort of moral conviction.<sup>7</sup>

I noted above that health is a substantive social value. There appears to be no reason why the state should shy away from promoting it. Health can be considered to be a good in itself. But beyond that, there are other reasons to endorse it. Recall that even Daniels thinks that health is a good in its contribution to normal species functioning. However, normal species functioning is not value-neutral; part of the good life for humans is to have normal human capacities; to function in a way that allows humans to experience the rational and physical capacities befitting one as a member of the human species. Also, one might argue that liberal values of liberty and equality are already given pride of place in liberal states and therefore states are not neutral, strictly speaking.

**IT IS IMPOSSIBLE TO MAINTAIN STRICT STATE NEUTRALITY TOWARD ALL SOCIAL VALUES WITHOUT LOSING EVEN CORE STATE FUNCTIONS**

Dale Murray [Prof. of Philosophy, University of Wisconsin-Baraboo], "The Massachusetts Health Plan, Individual Mandates, and the Neutrality of the Liberal State," *Journal of Medicine and Philosophy*, 36: 466–483, (2011)

One may ask whether the rescue, anti-free riding, and just sharing principles do not themselves manifest highly disputed, "parochial" conceptions of the good. First, however, they are social values, not valuations of the degree of goodness of this or that condition in a given person's own individual life, by that individual person. They are about relationships in the society, not individual utility (Menzel, 1999). Moreover, these three values and principles are apparently very widely shared in US moral culture (including, I would guess, Massachusetts' moral culture). According to liberal neutralists, almost every liberal state, while it should be neutral among highly different conceptions of individual good ("individual utility"), cannot be neutral about all social values. I say "almost" because right libertarians will claim that the night watchman state is neutral with respect to all social values.<sup>10</sup> While neutralists think that taking a neutral stance toward the most disputed social values may be the wisest course, the state should not be neutral among all. Whether the advocates of mandated health insurance are correct in claiming that the particular social values critical to making an argument for a mandate are in fact values on which the state need not be neutral is of course a question that requires critical pursuit. The first order of business in making such a judgment, however, is to discern what those values are and how deeply and widely rooted they are in the society. Otherwise, "neutrality" gets used to jettison so much collective action that the resulting state is hardly "liberal" anymore. With this said, far right libertarians may not accept that state neutrality is upheld if rescue, anti-free riding, and just-sharing principles are social values. However, right libertarians do appear to accept at least the anti-free riding principle. They may need to reevaluate if they can endorse this principle or whether it is plausible to endorse such a stringent version of state neutrality.

**RIGHT TO HEALTH ENTAILS BOTH POSITIVE AND NEGATIVE OBLIGATIONS FOR GOVERNMENTS.**

Alicia Ely Yamin, JD, MPH [Harvard School of Public Health; human rights attorney who at the time of writing was working with nongovernmental organizations in Latin America]. "The Right to Health Under International Law and Its Relevance to the United States," American Journal of Public Health, July 2005, Vol 95, No. 7.

Since the end of the Cold War, the interdependence and indivisibility of economic, social, and cultural rights and civil and political rights has been broadly accepted.<sup>20</sup> Further, there is now widespread agreement that the right to health entails both negative freedoms (e.g., from nonconsensual medical treatment and experimentation) and positive freedoms or entitlements (e.g., access to care).<sup>1</sup> Under international law, states that are party to a variety of different treaties assume tripartite obligations: (1) to respect the right to health by refraining from direct violations, such as systemic discrimination within the health system; (2) to protect the right from interference by third parties, through such measures as environmental regulation of third parties; and (3) to fulfill the right by adopting deliberate measures aimed at achieving universal access to care, as well as to preconditions for health.<sup>1,10</sup> Thus, it is wrong to think of the right to health in terms of a package of services, even a package extending beyond medical care.

**RIGHTS FRAMEWORK MAKES LINK BETWEEN HEALTH AND DEMOCRACY EXPLICIT  
AND PLACES HEALTH POLICY DECISIONS INTO THE DOMAIN OF LAW.**

Alicia Ely Yamin, JD, MPH [Harvard School of Public Health; human rights attorney who at the time of writing was working with nongovernmental organizations in Latin America]. "The Right to Health Under International Law and Its Relevance to the United States," *American Journal of Public Health*, July 2005, Vol 95, No. 7.

Realization of the right to health further implies providing individuals and communities with an authentic voice in decisions defining, determining, and affecting their well-being.<sup>1,19</sup> Public health has a long tradition of recognizing that participation is integral to health promotion.<sup>21</sup> Further, analyses of the importance of structural determinants of health and political economic context are increasingly common.<sup>3–6,22–25</sup> Framing health as a right adds to the growing literature in social epidemiology that links health with social justice; it does this by first making explicit the link between health and the construction of a functional democracy. That is, health-related resource distribution, evidence of discrimination and disparities, and the like are analyzed not just in terms of their impact on health status but also their relation to laws, policies, and practices that limit popular participation in decisionmaking and, in turn, the establishment of a genuinely democratic society.<sup>2,6,26</sup> Second, failure to respect, protect, or fulfill responsibilities relating to health are construed not only in terms of ensuing social or economic problems, but also explicitly in terms of the accountability of the state and, to a certain extent, other actors, under national and international law.<sup>1,6,10–12,26</sup> Thus, a human rights framework simultaneously acknowledges health as inherently political—intimately bound up with social context, ideologies, and power structures—and removes health policy decisions from being matters of pure political discretion by placing them squarely into the domain of law.



## RIGHTS DISCOURSE GOOD

Alicia Ely Yamin, JD, MPH [Harvard School of Public Health; human rights attorney who at the time of writing was working with nongovernmental organizations in Latin America]. "The Right to Health Under International Law and Its Relevance to the United States," *American Journal of Public Health*, July 2005, Vol 95, No. 7.

In this context, the discourse of rights can reconfigure public expectations and commitments. For instance, when access to health care is construed as a matter of right, it is not dependent on good behavior. Even if there is a widespread belief that ill health is often the result of poor personal choices, just as this society provides defense counsel to criminal defendants, who arguably may have exercised poor choices, so too would the state have an obligation to ensure access to health facilities, goods, and services.<sup>1</sup> Further, once health is framed as a right, the contours of debates about the role of the state and markets shift. Despite discontent with inefficiencies and poor quality of care in many industrialized countries, the government's obligations with respect to health care are well entrenched in society as well as law in most of the developed world.<sup>39,40</sup>

## **MORE REASONS HEALTH OUGHT TO BE TREATED AS A RIGHT**

Alicia Ely Yamin, JD, MPH [Harvard School of Public Health; human rights attorney who at the time of writing was working with nongovernmental organizations in Latin America]. "The Right to Health Under International Law and Its Relevance to the United States," *American Journal of Public Health*, July 2005, Vol 95, No. 7.

Moreover, constitutional law can and does change to accommodate changes in public perceptions and political philosophy. As Archibald Cox argued, accepting that government is "not merely about policy but also has affirmative obligations to satisfy basic necessities of citizens [including medical attention] is the next great challenge of North American constitutionalism."<sup>50</sup>(p118–119) Invoking legal realism, Cass Sunstein goes further, suggesting that "with a modest shift in personnel" on the Supreme Court, economic and social rights, including health, "could well be included in our constitutional understandings, and certainly in the nation's constitutive commitments, which is where they belong."<sup>41</sup>(p108) Even if—especially if—such a "shift in personnel" is not immediately forthcoming, human rights as enshrined in international law offer a powerful alternative discourse to the prevailing market-oriented one through which to understand and mobilize public concern regarding issues such as disparities in treatment and access to care in the United States.<sup>10,41</sup> Public consciousness can precede and encourage legal recognition, which in turn reinforces public awareness of concerns in terms of rights.<sup>41</sup>

**THE CURRENT US HEALTH CARE SYSTEM IS DISCRIMINATORY AND UNFAIR –  
VIOLATES RIGHTS ENSHRINED IN INTERNATIONAL AND DOMESTIC LAW.**

Alicia Ely Yamin, JD, MPH [Harvard School of Public Health; human rights attorney who at the time of writing was working with nongovernmental organizations in Latin America]. “The Right to Health Under International Law and Its Relevance to the United States,” *American Journal of Public Health*, July 2005, Vol 95, No. 7.

Major reviews of the more than 1000 studies done recently on health disparities in the United States have found consistent, credible, and robust evidence of differences based on race and ethnicity in diagnostic procedures as well as therapeutic interventions. 55–58 A national study by the Department of Health and Human Services’ Agency for Healthcare Research and Quality determined that “racial, ethnic, and socioeconomic disparities are national problems that affect health care at all points in the process, at all sites of care, and for all medical conditions—in fact, disparities are pervasive in our health care system.”<sup>58</sup> A human rights analysis of this situation determines first the normative obligation and then the violation. As a party to the Race Convention, the US government has undertaken not just a moral but a legal obligation “to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of . . . the rights to public health [and] medical care.”<sup>14</sup>(article5(e)(iv)) Under the Race Convention, the government undertakes not just to sanction incidents of discrimination but to affirmatively eradicate racial discrimination in all its forms.<sup>14</sup> Further, even under devolution or decentralization schemes, the ultimate accountability for state and local law and policy resides with the federal government under international law. Thus, when state or local governments fail to eliminate health disparities, the federal government cannot divest itself of final responsibility.<sup>59</sup> On the domestic level, Title VI of the Civil Rights Act of 1964 prohibits discrimination in all health care activities receiving federal funding, which virtually all do in one form or another.<sup>53</sup> Title VI, together with its regulations, arguably prohibits both intentional and disproportionate adverse impact discrimination.<sup>17,60, 61,62(p953),63</sup> Under international law it is clear that discrimination under international law need not be intentional; it need only have the effect of impairing or nullifying the enjoyment of rights to constitute a violation.<sup>1,14,64</sup> In its review of the United States’ country report in 2001, the UN committee that monitors compliance with the Race Convention (CERD) specifically noted its concern with respect to “persistent disparities in the enjoyment of, in particular, . . . access to public and private health care” and recommended that the United States “take all appropriate measures, including [affirmative] measures . . . to ensure [these rights].”<sup>65</sup>(¶398) The CERD’s concluding observations make it clear that a right-to-health framework goes beyond both medical and ethical and quality-of-care issues to focus on state accountability. As illustrated by a 2003 Physicians for Human Rights report, a rights approach to racial disparities in treatment includes such issues as provider education and service delivery but emphasizes governmental accountability for redress, as well as for improved collection, analysis, and dissemination of appropriately disaggregated data that permits the detection of disparities and potential discrimination; it also includes the creation of effective enforcement mechanisms, such as a Health Section within the Civil Rights Division of the Department of Justice.<sup>56</sup>

*IMPLEMENTING UNIVERSAL HEALTH CARE: PATIENT HEALTH AND SYSTEM EFFICIENCY*

**ALLOWING THE PURCHASE OF MEDICAL CARE ABOVE THE ACCESS GRANTED TO EVERYONE WILL CREATE A DRAIN ON MEDICAL PROFESSIONALS INTO THE PRIVATE SPHERE**

Amy Guttman [Professor of Political Science, Communications, and Philosophy, University of Pennsylvania], "For and Against Equal Access to Healthcare," *The Milbank Memorial Fund Quarterly. Health and Society*, Vol. 59, No. 4 (1981), pp.542-560

But there is a second restriction of consumer market freedom sanctioned by the equal access principle: the limitation upon freedom to buy health care goods above the level publicly provided. Aside from reasserting the primary values of equality, there is at least one plausible argument for such a restriction. Without restricting the free market in extra health care goods, a society risks having its best medical practitioners drained into the private market sector, thereby decreasing the quality of medical care received by the majority of citizens confined to the publicly funded sector. The lower the level of public provision of health care and the less elastic the supply of physicians, the more problematic (from the perspective of the values underlying equal access) will be an additional market sector in health care.

## **FORCING THOSE WHO MAKE RISKY HEALTH CHOICES TO BEAR ADDITIONAL COSTS REQUIRES EXTENSIVE KNOWLEDGE**

Amy Guttman [Professor of Political Science, Communications, and Philosophy, University of Pennsylvania], "For and Against Equal Access to Healthcare," *The Milbank Memorial Fund Quarterly. Health and Society*, Vol. 59, No. 4 (1981), pp.542-560

Another important criticism of the equal access principle cuts across advocacy of the free market and government regulation of health care. Supporters of both views might consistently ask whether it is fair to provide the same level of access for all people, including those who voluntarily adopt bad health habits, and who quite knowingly and willingly take greater-than-average risks with their lives and health. Even if it might be unjust not to provide health care for those people once the need arises, why would it not be fair to force those who choose to drink, smoke, rock climb, and skydive also to bear a greater burden of their ensuing medical costs than that borne by people who deliberately avoid these risky pursuits? An equal access principle seems to neglect the distinction between voluntary and nonvoluntary health risks in its eagerness to ensure that all people have an equal opportunity to receive appropriate health care.

Gerald Dworkin (1979) extensively and convincingly argues that it would not be unfair to force individuals to be financially liable for voluntarily undertaken health risks, but only under certain conditional assumptions. These include our ability 1) to determine the relative causal role of voluntary versus nonvoluntary factors in the genesis of illness; 2) to differentiate between purely voluntary behavior and what is nonvoluntary or compulsive; and 3) to distinguish between genetic and nongenetic predispositions to illness. For example, to satisfy the first condition one would have to determine the relative causal role of smoking and environmental pollution in the genesis of lung cancer; to fulfill the second, one must know when smoking (or drinking or obesity) is voluntary and when it is compulsive behavior; and to satisfy the third condition, one must distinguish among those who smoke and get cancer, and those who smoke and do not. In addition, so long as there are no good institutional mechanisms for monitoring certain risky activities or for differentiating between moderate and immoderate users of unhealthy substances, qualifying the equal access principle to take account of voluntary health risks is likely to create more unfairness rather than less. Finally, given great inequalities in income distribution, the poor will be less able to bear the consequences of their risky behavior than will the rich, creating a situation of unfairness at least as serious as the unfairness of equally distributing the burdens of health care costs between those who voluntarily impose risks upon themselves and those who do not. With respect to the health hazards of overeating and obesity, for example, the rich have recourse to expensive programs of weight control unavailable to the poor. Since we have such scanty knowledge of situations when sickness can be attributable to voluntary health risks, criticisms of the equal access principle from this perspective have more weight in principle than they do in practice.

## **UNIVERSAL ACCESS TO HEALTHCARE REQUIRES A SIGNIFICANT ROLE FOR GOVERNMENT**

Daniel M. Hausman [Prof. of Philosophy, University of Wisconsin – Madison], “A LOCKEAN ARGUMENT FOR UNIVERSAL ACCESS TO HEALTH CARE,” *Social Philosophy and Policy*, Volume 28, Issue 2 (May 2011), pp 166-191

By “universal effective access” to a particular set of health care services, I shall mean the state of affairs in which all residents are normally able to get these services without severe difficulty or hardship. Universal effective access does not require state provision, but it cannot in fact be secured without a good deal of government involvement. The high cost of many treatments and the unpredictability of needs for them make it impossible for individual savings to provide universal access.<sup>9</sup> Voluntary private insurance fails to provide universal access, because it is beyond many people’s means, and severe adverse selection problems<sup>10</sup> cause market failures. How much government involvement is required depends in part on the set of health care services to which access should be universal, and, as we shall see, the Lockean defender of universal effective access will have a different conception of which services everyone should be able to access than other proponents of universal access. Although I will be concerned with what health care services people should have access to, this essay will not be concerned with problems of implementing universal access.

**IF SOCIETY IS COMMITTED TO PROVIDING ACUTE EMERGENCY CARE TO ANYONE REGARDLESS OF NEEDING, MANDATING INSURANCE COVERAGE IS THE ONLY WAY TO ENSURE THAT EVERYONE PAYS HIS FAIR SHARE OF THE STATISTICALLY FORESEEABLE COSTS**

Dale Murray [Prof. of Philosophy, University of Wisconsin-Baraboo], "The Massachusetts Health Plan, Individual Mandates, and the Neutrality of the Liberal State," *Journal of Medicine and Philosophy*, 36: 466–483, (2011)

If society refuses to form a common pool for sharing the costs of care (for instance, some sort of single-payer system), the advantages in (1) above of achieving universal access remain equally attractive. Moreover, suppose that the society has already decided it will not allow uninsured individuals to languish at hospital doorsteps for lack of insurance and therefore requires hospitals to provide emergency care regardless. If people are then allowed to go without insurance, society is effectively inviting those who regard themselves as healthy enough to do so to go without paying their share of statistically inevitable expenses.

**CONSENSUS IS THAT UHC IS A FUNDAMENTAL GOAL—PROBLEM IS IMPLEMENTATION.**

Stuckler, David [University of Oxford, UK; London School of Hygiene and Tropical Medicine, UK], Andrea B. Feigl [Harvard School of Public Health, USA], Sanjay Basu [University of California San Francisco, USA], and Martin McKee [London School of Hygiene and Tropical Medicine, UK]. "The Political Economy of Universal Health Coverage," *Background paper for the Global Symposium on Health Systems Research*. November 16-19, 2010.

Since the 1970s, there has been a near consensus among the public health community that Universal Health Care Coverage (UHC) should be a fundamental goal.<sup>4, 5</sup> At the conference in Alma Ata<sup>6</sup> and, subsequently in Ottawa<sup>7</sup>, commitments were made to pursue equitable systems of healthcare, which would provide access to all for point-of-entry healthcare services, so that no matter what a person's ailment, there is a person or group who can coordinate services. Decades later, progress is elusive. UNICEF, the World Bank, the Rockefeller Foundation, and physician advocacy groups argued that many countries could not afford UHC,<sup>8, 9</sup> instead promoting a Selective Health Care model, based on a limited set of cost-effective technologies (mainly the GOBI interventions) as a first step toward achieving the vision established at Alma-Ata.<sup>10, 11</sup> This partial model, with substantial private-sector involvement, continues to dominate the development of health systems in resource-poor settings.



**ANY OF VARIOUS FINANCIAL PLANS COULD BE EFFECTIVE, BUT THE U.S. MUST BE REALISTIC AND WILLING TO HAVE A CANDID DEBATE ABOUT TAXES.**

Lawrence D. Brown [Professor of Health Policy and Management, Mailman School of Public Health, Columbia University]. "Comparing Health Systems in Four Countries: Lessons for the United States," American Journal of Public Health, January 2003, Vol 93, No. 1.

In all 4 systems the national government sets a statutory framework for financing universal coverage. (In Canada the provinces must meet centrally defined conditions for participation in central/provincial fund-sharing arrangements.) How they raise these monies differs substantially, however: Great Britain's National Health Service draws mainly on general revenues; 70% of Canada's health bill comes from national and provincial general revenues; Germany relies primarily on work-based social insurance contributions; and—the most dramatic evolutionary development in this quartet—France increasingly supports its social insurance regime with general revenues that tap a broad range of wealth. None of these approaches is plainly superior to the others; they all "work," and they all carry their burden of political and economic stress. France and Germany also have various degrees and types of cost sharing by patients. The good news for the United States is that in essence any major funding approach will serve. The bad news is that no such approach seems close to commanding consensus, and feuding over the merits of funding strategies aggravates the chronic righteous strife among proponents of reform that (given the imposing strength of the opposition) has heavily damaged reform prospects. One contingent contends that a "single payer" (general revenue—based) system is best. Another believes that the success of Social Security and Medicare validates a social insurance strategy. Whereas no other nation believes that universal coverage can be won and sustained without candid debate about taxes, a prominent American reform camp wants to build on the private employer contributions that buy most US health insurance today. (Indeed the Clinton administration's reform plan of 1993 would have mandated such employer "premiums" precisely in order to avoid uttering the dreaded "t word.") Meanwhile, the widespread conviction that done right, universal coverage should require no new monies (tax-derived or other) beclouds the US reform debate. The system is said to be replete with waste that can be intelligently squeezed to yield abundant funds to rechannel resources from excessive use and payments to providers and toward coverage for the uninsured. (This too was a premise of the Clinton plan.)

**POLITICAL OPPOSITION STOPS CONSIDERATION OF SINGLE PAYER SYSTEM, BUT  
COULD STILL WORK AT STATE LEVEL**

Hsiao, William C. "The New England Journal of Medicine." State-Based Single-Payer Health Care. New England Journal of Medicine, 31 Mar. 2011. Web. 25 June 2012.  
<<http://www.nejm.org/doi/full/10.1056/NEJMp1100972>>.

The United States faces two major problems in the health care arena: the swelling ranks of the uninsured and soaring costs. The Patient Protection and Affordable Care Act (ACA) makes great strides in addressing the former problem but offers only modest pilot efforts to address the latter. Experience in countries such as Taiwan and Canada shows that single-payer health care systems can achieve universal coverage and control inflation of health care costs. Because of strong political opposition, however, the U.S. Congress never seriously considered a single-payer approach during the recent reform debate. Now Vermont, wishing to solve the intertwined problems of costs and access through systemic reform, is turning in that direction. Vermont Governor Peter Shumlin campaigned on a platform of single-payer health care, and Democratic legislative leaders are committed to this approach. In Vermont, the status quo in health care has become untenable. Despite numerous reforms over the past 15 years, Vermont's health care costs are escalating rapidly, straining the state budget, household incomes, and employers' bottom lines. More than 7% of Vermonters are uninsured, and another 15% have inadequate insurance.

**REFORMS RESULT IN UNIVERSAL COVERAGE, REDUCED COST AND CARE FOCUSED DELIVERY.**

Hsiao, William C. "The New England Journal of Medicine." State-Based Single-Payer Health Care. New England Journal of Medicine, 31 Mar. 2011. Web. 25 June 2012.  
<<http://www.nejm.org/doi/full/10.1056/NEJMp1100972>>.

The Vermont Legislature passed Act 128 in May 2010 authorizing a study to find the most viable and practical systemic solutions to these problems.<sup>1</sup> The goals are clear and ambitious: Vermont wants to achieve universal coverage, reduce the rate of cost increases, and create a primary care-focused, integrated delivery system. The question is how to achieve those goals. My team of health system analysts at the Harvard School of Public Health was commissioned by the Vermont Legislature to develop and evaluate three options for health system reform and determine which option would best achieve the stated goals. We conducted extensive fiscal, legal, institutional, and stakeholder analyses in Vermont to gain an in-depth understanding of the hurdles confronting any such plan and to design ways of overcoming or navigating around them. Our findings presented a striking picture. Vermont faces a \$150 million budget shortfall. Employers argue that health care costs jeopardize their businesses' financial viability, while families struggle to pay out-of-pocket health care costs. Vermont businesses and workers are unwilling to spend more for health care. On the other hand, Vermonters are also largely unwilling to reduce their level of benefits. Our analysis found that, on average, Vermonters have rich insurance benefits approaching the ACA's "platinum" standard. Similarly, physicians and hospitals are unwilling to accept reductions in their net incomes.

## **SINGLE PAYER SYSTEMS SOLVE.**

Hsiao, William C. "The New England Journal of Medicine." State-Based Single-Payer Health Care. *New England Journal of Medicine*, 31 Mar. 2011. Web. 25 June 2012.  
<<http://www.nejm.org/doi/full/10.1056/NEJMp1100972>>.

Our analyses led us to adopt several design principles that shaped our recommended design. First, we wanted to design a system capable of achieving universal coverage and reducing the cost inflation rate. Any increases in spending to cover the uninsured and underinsured would have to come from savings generated by systemic reforms. Any financing mechanism should not increase the costs to the state, businesses, and households. Second, we aimed to maintain Vermonters' current average benefits. Third, we sought to maximize federal revenues from all sources. Fourth, we would not reduce overall net income of physicians, hospitals, or other providers. Finally, we sought to eliminate the perverse incentives inherent in the fee-for-service system, through risk-adjusted capitation payment plus performance bonuses, to provide incentives for the formation of accountable care organizations and care integration. We found that the system capable of producing the greatest potential savings and achieving universal coverage was a single-payer system — one insurance fund that covers everyone with a standard benefit package, paying uniform rates to all providers through a single payment mechanism and claims-processing system. Our analysis showed that Vermont could quickly save almost 8% in health care expenditures through administrative simplification and consolidation, plus another 5% by reducing fraud and abuse.

**PUBLIC/PRIVATE PARTNERSHIP CHECKS COSTS.**

Hsiao, William C. "The New England Journal of Medicine." State-Based Single-Payer Health Care. New England Journal of Medicine, 31 Mar. 2011. Web. 25 June 2012.  
<<http://www.nejm.org/doi/full/10.1056/NEJMp1100972>>.

We recommended that the single payer be a public–private partnership. An independent board with representation from both the major health care payers (employers, the state, and workers) and the major beneficiaries and recipients of payment (providers and consumers) would negotiate updates to the benefit package and payment rates. We also proposed contracting out claims administration through a competitive bid to create incentives to develop more efficient systems. This system reduces the rate of cost increases over time by insulating major decisions about health care spending from politics, as well as by paying providers through capitation rather than fee for service, promoting delivery-system integration, and reducing the practice of defensive medicine by implementing a no-fault medical malpractice system. All told, we estimated that Vermont could save 25% in health care expenditures over 10 years (estimated savings for the first 5 years are shown in the table. Estimated Impact of the Recommended Single-Payer Plan for Vermont.).

## **ECONOMIC MODELS INDICATE SINGLE PAYER SYSTEM WOULD WORK.**

Hsiao, William C. "The New England Journal of Medicine." State-Based Single-Payer Health Care. *New England Journal of Medicine*, 31 Mar. 2011. Web. 25 June 2012.  
<<http://www.nejm.org/doi/full/10.1056/NEJMp1100972>>.

Eligibility for coverage in the system would be based solely on proof of Vermont residency, the same requirement currently used by Vermont Medicaid; this approach effectively divorces health benefits from employment. However, we proposed to finance the system through a payroll contribution on all Vermont wages, split between employer and employee, to preserve the federal tax treatment of health benefits — a tax expenditure worth \$400 million to \$500 million in Vermont. We recommended delaying the implementation of the single-payer system until after Vermont's insurance exchange has been operating for a year, at which point the state will have a basis for arguing for a waiver from the ACA requirements and estimating the amount of a federal block grant it would receive before 2017, when current ACA law allows for waivers.<sup>1</sup> We used two economic models to estimate the impact of the proposed system. We fed estimated savings and costs under the single-payer system into a MicroSimulation Model, developed by the Massachusetts Institute of Technology's Jonathan Gruber, which simulated the likely responses to the ACA by employers and low-income workers and estimated the amount of state and federal spending under the law, as well as computing the payroll contribution rates necessary to finance our plan. We then fed those results into a macroeconomic model developed by Regional Economic Models to estimate the effects on jobs and the gross state product that would result from additional spending for health care when more people were covered and the increase in household income and consumption when insurance premiums decreased with a single-payer plan. The models predicted that, as compared with implementing the ACA, the single-payer system would result in lower spending by employers, the state, and households and in the creation of more jobs in Vermont. For example, without single-payer reforms, we predict that employers would pay 12% of their payrolls in health insurance premiums in the first year, with further increases to follow.

**VERMONT SINGLE PAYER HAS FEDERAL BACKING AND PROVIDES A TEMPLATE FOR THE NATION.**

Hsiao, William C. "The New England Journal of Medicine." State-Based Single-Payer Health Care. New England Journal of Medicine, 31 Mar. 2011. Web. 25 June 2012.  
<<http://www.nejm.org/doi/full/10.1056/NEJMp1100972>>.

The governor has already introduced legislation establishing the first building blocks of a single-payer system: payment reform, the creation of the independent board, and the mandate to build Vermont's health insurance exchange as a platform for a single-payer infrastructure. Legislation establishing universal coverage and its financing will follow, when the state can obtain waivers from Medicare's and Medicaid's provider-payment rules and the ACA's individual mandate and subsidy rules. Innovative state reforms are being encouraged, as illustrated by President Obama's support for the Wyden–Brown bill,<sup>2</sup> which would grant waivers from ACA requirements in 2014 if states can meet the ACA's goals. The Vermont single-payer plan certainly can. Perhaps we are at the dawn of systemic reform in U.S. health care. The Vermont single-payer plan will never be as efficient as Taiwan's or Canada's because it must work within the bounds of federal laws and programs and the realities of porous state borders. Nevertheless, it can produce substantial savings to fully fund universal coverage, reduce health care costs for most businesses and households over time, and reform a fragmented delivery system. Of course, someone will bear the burden — mostly the private insurance industry and high-wage businesses that don't currently offer insurance. But if Vermont can navigate its political waters and successfully implement this plan, it will provide a model for other states and the country as a whole

**EMPIRICALLY NATIONS HAVE BEEN ABLE TO CONTAIN THE COSTS OF UHC EFFECTIVELY WITHOUT GENERATING PROBLEMATIC WAITING LISTS FOR MEDICAL SERVICES.**

Lawrence D. Brown [Professor of Health Policy and Management, Mailman School of Public Health, Columbia University]. "Comparing Health Systems in Four Countries: Lessons for the United States," *American Journal of Public Health*, January 2003, Vol 93, No. 1.

Although the 4 nations spend a smaller share of their national resources on health care than the United States does, cost containment has long been a preoccupation in each and all. (Great Britain is arguably a case apart. There, reorganization and better management of the National Health Service have—until recently—been successfully offered as alternatives to the infusions of cash the Blair government was eventually moved to promise.) The 4 nations pay their physicians less and provide fewer specialized and highly technical services than the United States does, and all expect that structured negotiations between payers and providers will hold the line on costs. These staples of cost containment seem increasingly insufficient to counter the fundamental challenges all nations face—growing and aging populations, technological progress, inflation, wage pressures, and rising popular expectations<sup>1</sup>—and so in their sundry fashions, the 4 countries try to cap health spending. In Great Britain and Canada, the public health care budget is itself a ceiling. In France, since 1996 Parliament has legislated a national spending target annually. Germany has tried to link health spending increases to the growth of workers' wages. Only in Great Britain have these public constraints generated highly controversial waiting lists, and these, says Light,<sup>2</sup> are mainly limited to elective referrals to specialists. Waiting lists occasionally appear in Canada, but Deber<sup>1</sup> argues that these vary with place and procedure and are a minor, albeit well-publicized, concern. "Rationing" is a nonissue in France and Germany. Containing costs is never easy, but the 4 nations have done it—indeed, in the British case perhaps too well.



**UNIVERSAL HEALTH CARE SYSTEMS, WHILE LESS SPECIALIST DRIVEN, ARE MORE EFFICIENT.**

Lawrence D. Brown [Professor of Health Policy and Management, Mailman School of Public Health, Columbia University]. "Comparing Health Systems in Four Countries: Lessons for the United States," American Journal of Public Health, January 2003, Vol 93, No. 1.

The 4 nations all use public authority and planning to control the number and distribution of hospitals and physicians. Contrary to conventional wisdom, such constraints do not necessarily make the system "smaller" or harder to access. Rodwin's Table 2,3 for example, shows that on most measures of resources and utilization—for instance, active physicians per thousand population; total inpatient hospital beds, physician visits, and hospital days per capita; admission rates to and lengths of stay in hospitals—France surpasses the United States. These limits do make the systems less specialist driven and technology intensive, however, which seems to be how they register savings for the nations in question.

## **UNIVERSAL HEALTH CARE SYSTEMS PRODUCE HIGHER PATIENT SATISFACTION.**

Lawrence D. Brown [Professor of Health Policy and Management, Mailman School of Public Health, Columbia University]. "Comparing Health Systems in Four Countries: Lessons for the United States," American Journal of Public Health, January 2003, Vol 93, No. 1.

In all 4 nations, citizens record high (though not unreserved or uncritical) satisfaction with their health care systems. No one views national health insurance as a big mistake and wants to start over. The vices of the US system—40 million uninsured people, an additional (and sizable) number with inadequate coverage, wide disparities in access and quality—are thought to overwhelm such modest and distinctive virtues as more extensive integration of services and more advanced analytic capacity. The foreign systems' costs are routinely and rhetorically said to be in "crisis." The systems themselves are not.

American public opinion voices no small dissatisfaction with the US system and considerable support for major, even fundamental, changes in it. The rub, however, is that this grouching does not yield a clear mandate for anything very different from the status quo. Despite years of intense opinion polling, policymakers remain unsure precisely what people are upset about (beyond the impossibility of enjoying ready access to fine care at minimal cost) and what they think would work better. Nor is this so odd after all: the same political leaders who quietly pushed arcane payment reforms in public programs have generally declined to launch searching public discussions of the big and touchy redistributive and regulatory issues and tradeoffs on which health reform turns. Bill Clinton's unavailing and politically painful effort to break the pattern reaffirmed it instead. A perplexed public has therefore come to view health care reform as something like shopping for shoes: "We think we are in the mood to buy a health care reform today but not that style or fit, so keep showing us others." The technical opacity of the debate, not to mention continuing skepticism of anything "made in Washington," inhibit grassroots mobilization, citizen education, and other key concomitants of vigorous pluralist politics. No one seems to have a clue how to make well-documented dissatisfaction kindle a political fire under health reform.

**FRENCH HEALTHCARE—AN INSTANCE OF UHC—IS THE BEST IN THE WORLD.**

Taylor, Adam. "Yes, The US Could Probably Learn A Lot From The French Health Care System." Business Insider. N.p., 2 July 2012. Web. 03 July 2012. <<http://www.businessinsider.com/french-healthcare-system-2012-7>>.

In 2000, the World Health Organization took a long hard look at the world's healthcare systems, and ranked France as the best in the world. The US ranked 37th. Since that point France has repeatedly been called the best system in the world, to the point where doing so became a cliché. Unfortunately, the world isn't quite so simple, and critics argue that searching for the "best" healthcare system in the world may be futile — there's simply too many variables to produce meaningful results. WHO's report in particular has been criticized for the weight it gave to cost efficiency, healthy living, and life expectancy (the organization apparently declined to rank countries in the 2010 World Health Report). Regardless, we think that the French system may have something to teach the US. For one thing, other more recent sources have given some credence to the WHO's findings. One, published by US journal Health Affairs in 2008, found that between 2002-2003, France had the lowest rate of mortality amenable to health care — that is, the lowest death rate from ailments that could probably have been prevented by proper healthcare — of 19 developed countries. The US, on the other hand, came 19th.

## **FRENCH SYSTEM PRODUCES HIGH SATISFACTION AMONG CITIZENS.**

Taylor, Adam. "Yes, The US Could Probably Learn A Lot From The French Health Care System." Business Insider. N.p., 2 July 2012. Web. 03 July 2012. <<http://www.businessinsider.com/french-healthcare-system-2012-7>>.

More importantly, however, is the fact that the French system and the US system actually share some key similarities. It's tempting for Americans to compare their healthcare systems to that of English-speaking countries like the UK and conclude that things aren't so bad, or that the systems are so different that change is impossible. The UK in particular has a full-National Health Service that is subject to near constant negative coverage from the UK tabloids and appears to be entering the first stages of privatization — hardly enticing. France, on the other hand, doesn't have a "National Health Service" — it has National Health Insurance. Many French people don't even consider their health system "socialized", Paul V. Dutton, executive director of the Interdisciplinary Health Policy Institute at Northern Arizona University, writes in *Differential Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*. Like the American system, the French system prides itself on choice. "The vast majority of ambulatory care physicians in France are in private practice and patients enjoy extraordinary freedom of choice among them. Virtually all primary care providers and specialists participate in the nation's public health insurance system, *Sécurité Sociale*", Dutton writes. Notably, France also has the largest private hospital system in Europe. This system, whether its socialized or not, is (at worst) fairly successful. Last year a Deloitte poll found that 55% of French respondents believed their system was the best in the world. Contrast that with a March 2012 Gallup poll which found that 81% of US respondents had a great deal or a "fair amount of worry about the availability and affordability of healthcare." That's probably a pretty unsuccessful health care system, and remember — in 2010 the US spent 17.4% of its GDP on healthcare, while France spent around 11.8%. Crucially, the French system shows how the American system could grow. The French system of National Health Insurance that evolved slowly to meet needs, Victor G. Rodwin wrote in a 2004 academic article, "The Health Care System Under French National Health Insurance: Lessons for Health Reform in the United States". Rodwin argues that "patchwork accumulation of federal, state, and employer-sponsored plans" could gradually work in the US, as long as the country decides to "recognize the legitimate role of government in overseeing the rules and framework within which these actors operate." Whether that actually happens is anyone's guess.

*INTERNATIONAL LAW*

**THE RIGHT TO HEALTHCARE IS CODIFIED IN INTERNATIONAL LAW—RIGHTS PARADIGM KEY TO GOVERNMENT ACCOUNTABILITY.**

Alicia Ely Yamin, JD, MPH [Harvard School of Public Health; human rights attorney who at the time of writing was working with nongovernmental organizations in Latin America]. “The Right to Health Under International Law and Its Relevance to the United States,” *American Journal of Public Health*, July 2005, Vol 95, No. 7.

In recent years, there have been considerable developments in international law with respect to the normative definition of the right to health, which includes both health care and healthy conditions.

These norms offer a framework that shifts the analysis of issues such as disparities in treatment from questions of quality of care to matters of social justice. Building on work in social epidemiology, a rights paradigm explicitly links health with laws, policies, and practices that sustain a functional democracy and focuses on accountability. In the United States, framing a well-documented problem such as health disparities as a “rights violation” attaches shame and blame to governmental neglect. Further, international law offers standards for evaluating governmental conduct as well as mechanisms for establishing some degree of accountability.

**THE UDHR, ICESCR, AND WHO CONSTITUTION ALL ENSHRINE THE RIGHT TO HEALTH. THE STATE IS OBLIGATED TO LEVEL THE SOCIAL PLAYING FIELD WITH REGARD TO HEALTH, WITHIN A STANDARD OF REASONABLENESS.**

Alicia Ely Yamin, JD, MPH [Harvard School of Public Health; human rights attorney who at the time of writing was working with nongovernmental organizations in Latin America]. "The Right to Health Under International Law and Its Relevance to the United States," *American Journal of Public Health*, July 2005, Vol 95, No. 7.

The first notion of a right to health under international law is found in the 1948 Universal Declaration of Human Rights (hereafter called Declaration), which was unanimously proclaimed by the UN General Assembly as a common standard for all humanity.<sup>7</sup> The Declaration sets forth the right to a "standard of living adequate for the health and wellbeing of himself and his family, including . . . medical care and . . . the right to security in the event of . . . sickness, disability . . . or other lack of livelihood in circumstances beyond his control." <sup>7</sup>(article 25) The Declaration does not define the components of a right to health; however, they both include and transcend medical care. The Cold War polarized countries' positions on human rights. In 1966, instead of the indissoluble whole reflected in the Declaration, twin covenants on civil and political rights and economic, social, and cultural rights were promulgated.<sup>8</sup> The right to health was included in the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12 of the ICESCR explicitly sets out a right to health and defines steps that states should take to "realize progressively" "to the maximum available resources" the "highest attainable standard of health," including "the reduction of the stillbirth- rate and of infant mortality and for the healthy development of the child"; "the improvement of all aspects of environmental and industrial hygiene"; "the prevention, treatment and control of epidemic, endemic, occupational and other diseases"; and "the creation of conditions which would assure to all medical service and medical attention in the event of sickness."<sup>9</sup>(article 12(2)) The language of progressive realization and maximal available resources, which suggests different standards for different countries, does not easily jibe with the absoluteness with which people in the United States generally think about rights. Yet in practice, due process and other civil rights may vary just as much. Indeed, the egregious disparities among countries, and in particular between the global north and south, suggest not the irrelevance of defining a right to health but rather the need to situate state obligations within a global political economy in which international institutions and third-party states often exercise inordinate influence over developing countries' economies and policies. The right to health demands, as do all human rights, "international assistance and cooperation."<sup>1,9</sup>(article2)–<sup>11</sup> The reference to a "highest attainable standard" of health, taken from the World Health Organization constitution,<sup>12</sup> builds in a reasonableness standard.<sup>10–13</sup> That is, the state has a role to play in leveling the social playing field with respect to health; however, there are factors that are beyond the state's control.<sup>1,10,11</sup> Furthermore, the highest attainable standard will necessarily evolve over time, in response to medical inventions, as well as demographic, epidemiological, and economic shifts.

## **THERE'S BROAD INTERNATIONAL CONSENSUS ON THE RIGHT TO HEALTH**

Alicia Ely Yamin, JD, MPH [Harvard School of Public Health; human rights attorney who at the time of writing was working with nongovernmental organizations in Latin America]. "The Right to Health Under International Law and Its Relevance to the United States," American Journal of Public Health, July 2005, Vol 95, No. 7.

In addition to the ICESCR, a wide array of international and regional treaties recognizes health as a rights issue, and these reflect a broad consensus on the content of the norms.<sup>14–19</sup> A review of the international instruments and interpretive documents makes it clear that the right to health as it is enshrined in international law extends well beyond health care to include basic preconditions for health, such as potable water and adequate sanitation and nutrition.<sup>1,10,11,13–19</sup>

**US VIOLATES INTERNATIONAL LAW BY NOT ADOPTING UNIVERSAL HEALTH CARE.**

Alicia Ely Yamin, JD, MPH [Harvard School of Public Health; human rights attorney who at the time of writing was working with nongovernmental organizations in Latin America]. "The Right to Health Under International Law and Its Relevance to the United States," American Journal of Public Health, July 2005, Vol 95, No. 7.

The relevance of consensually agreed-upon international norms to domestic debates on health policy would be self-evident in most of the world. However, historically the United States has been uniquely averse to accepting international human rights standards and conforming national laws to meet them.<sup>38</sup> The United States is also the only industrialized country in the world that does not provide a plan for universal health care coverage and some kind of legal recognition of a right to care.<sup>39,40</sup>



**US IS SIGNATORY TO A PLETHORA OF INTERNATIONAL AGREEMENTS REQUIRING RESPECT FOR THE RIGHT TO HEALTH.**

Alicia Ely Yamin, JD, MPH [Harvard School of Public Health; human rights attorney who at the time of writing was working with nongovernmental organizations in Latin America]. "The Right to Health Under International Law and Its Relevance to the United States," American Journal of Public Health, July 2005, Vol 95, No. 7.

The United States has undertaken international legal obligations relating to the right to health. The United States is a party to the International Convention on the Elimination of all Forms of Racial Discrimination (Race Convention), binding itself to take measures to eliminate racial disparities in public health and health care.<sup>14</sup> In other cases, the president has signed treaties signaling the government's intent to be bound by the provisions in the future, but the Senate has not given its "advice and consent" for ratification. Nevertheless, as a signatory to the ICESCR, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child, and others, the United States is bound not to contravene object or purpose of those treaties, an obligation that becomes relevant in, inter alia, assessing US trade and aid policies to the extent that these have health impacts.<sup>46</sup>

**THE CURRENT US HEALTH CARE SYSTEM IS DISCRIMINATORY AND UNFAIR –  
VIOLATES RIGHTS ENSHRINED IN INTERNATIONAL AND DOMESTIC LAW.**

Alicia Ely Yamin, JD, MPH [Harvard School of Public Health; human rights attorney who at the time of writing was working with nongovernmental organizations in Latin America]. “The Right to Health Under International Law and Its Relevance to the United States,” *American Journal of Public Health*, July 2005, Vol 95, No. 7.

Major reviews of the more than 1000 studies done recently on health disparities in the United States have found consistent, credible, and robust evidence of differences based on race and ethnicity in diagnostic procedures as well as therapeutic interventions. 55–58 A national study by the Department of Health and Human Services’ Agency for Healthcare Research and Quality determined that “racial, ethnic, and socioeconomic disparities are national problems that affect health care at all points in the process, at all sites of care, and for all medical conditions—in fact, disparities are pervasive in our health care system.”<sup>58</sup> A human rights analysis of this situation determines first the normative obligation and then the violation. As a party to the Race Convention, the US government has undertaken not just a moral but a legal obligation “to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of . . . the rights to public health [and] medical care.”<sup>14</sup>(article 5(e)(iv)) Under the Race Convention, the government undertakes not just to sanction incidents of discrimination but to affirmatively eradicate racial discrimination in all its forms.<sup>14</sup> Further, even under devolution or decentralization schemes, the ultimate accountability for state and local law and policy resides with the federal government under international law. Thus, when state or local governments fail to eliminate health disparities, the federal government cannot divest itself of final responsibility.<sup>59</sup> On the domestic level, Title VI of the Civil Rights Act of 1964 prohibits discrimination in all health care activities receiving federal funding, which virtually all do in one form or another.<sup>53</sup> Title VI, together with its regulations, arguably prohibits both intentional and disproportionate adverse impact discrimination.<sup>17,60, 61,62(p953),63</sup> Under international law it is clear that discrimination under international law need not be intentional; it need only have the effect of impairing or nullifying the enjoyment of rights to constitute a violation.<sup>1,14,64</sup> In its review of the United States’ country report in 2001, the UN committee that monitors compliance with the Race Convention (CERD) specifically noted its concern with respect to “persistent disparities in the enjoyment of, in particular, . . . access to public and private health care” and recommended that the United States “take all appropriate measures, including [affirmative] measures . . . to ensure [these rights].”<sup>65</sup>(¶398) The CERD’s concluding observations make it clear that a right-to-health framework goes beyond both medical and ethical and quality-of-care issues to focus on state accountability. As illustrated by a 2003 Physicians for Human Rights report, a rights approach to racial disparities in treatment includes such issues as provider education and service delivery but emphasizes governmental accountability for redress, as well as for improved collection, analysis, and dissemination of appropriately disaggregated data that permits the detection of disparities and potential discrimination; it also includes the creation of effective enforcement mechanisms, such as a Health Section within the Civil Rights Division of the Department of Justice.<sup>56</sup>

## **NEGATIVE EVIDENCE**

### *LIBERTARIANISM*

#### **GOVERNMENT WOULD NOT COMPENSATE PEOPLE FOR OTHER ARBITRARY ADVANTAGES; IT SHOULDN'T TRY TO DO SO IN HEALTHCARE**

Jeffrey A. Miron [Senior Lecturer in Economics, Harvard University; Senior Fellow, Cato Institute], "Public Option: Treatment Worse Than the Disease," *Cato.org*, Oct. 29, 2009. Accessed 10/13/2012.

In addition, it is logical for society to treat the differences in financial well-being due to health in the same way it treats differences due to IQ, athletic ability, race, country of origin, family background, and so on. These and other factors mean that some people, through no fault of their own, face hard financial circumstances, whether because of their ability to earn income or because of the higher prices they face for certain goods, such as health insurance.

Yet if society tried to equalize all differences resulting from, say, IQ, it would kill the incentive to work hard and destroy the economy's productive capacity. Thus, most people believe society should reduce these differences — by helping the poor — but most also recognize that society should not attempt to eliminate all differences.

**A PRINCIPLE OF EQUAL ACCESS TO HEALTHCARE REQUIRES DENYING THE WEALTHY  
THE FREEDOM TO BUY ADDITIONAL HEALTHCARE COVERAGE IN THE FREE MARKET**

Amy Guttmann [Professor of Political Science, Communications, and Philosophy, University of Pennsylvania], "For and Against Equal Access to Healthcare," *The Milbank Memorial Fund Quarterly. Health and Society*, Vol. 59, No. 4 (1981), pp.542-560

Equal access also places limits upon the market freedoms of some individuals, especially, but not exclusively, the richest members of society. The principle does not permit the purchase of health care to which other similarly needy people do not have effective access. The extent to which freedom of the rich must be restricted will depend upon the level of public provision for health care and the degree of income inequality. As the level of health care guaranteed to the poor decreases and the degree of income inequality increases, the equal access standard demands greater restrictions upon the market freedom of the rich. Where income and wealth are very unevenly distributed, and where the level of publicly guaranteed access is very low, the rich can use the market to buy access to health care goods unavailable to the poor, thereby undermining the effective equality of opportunity required by an equal access principle.

## FREE MARKET HEALTHCARE BETTER RESPECTS THE PRINCIPLE OF AUTONOMY

James Stacey Taylor [Associate Professor of Philosophy at The College of New Jersey], "Market-Based Reforms in Health Care Are Both Practical and Morally Sound," *Journal of Law, Medicine, and Ethics*, Special Issue: SYMPOSIUM 1: Conflicts of Interest in the Practice of Medicine, Volume 40, Issue 3, (Fall 2012), pp. 537–546

But, of course, not everyone is a utilitarian — and in the final analysis, it might transpire that utilitarianism is indeed mistaken. So, leaving aside considerations of human well-being (although to do so is admittedly rather odd in the context of a debate over health care!), what other ethical advantages does a market-based system hold over its State-based alternative? There are at least two — both of which focus on its essentially voluntary nature. The first and simplest of these is that a voluntary system of health care will respect the autonomy of persons in a way that the State provision of health care will not. Recall that the State will typically secure the resources that it needs to provide health care to its citizens through a system of taxation. While taxation is not necessarily coercive (some persons might support the State's policies wholesale, and so would voluntarily donate to it at a level equal to or greater than their tax burden), many persons will only pay their taxes because the State's demands that they do so are backed up by the threat of force. Many people, then, will be coerced into paying their taxes. As such, then, they will suffer from a diminution in their autonomy with respect to their tax-paying actions, for they will have autonomously decided to cede a certain degree of control over their actions to the State in order to avoid the penalties that they are threatened with for non-payment.<sup>20</sup> By contrast, a voluntary, commercial system of health care provision will secure the health care resources that it distributes non-coercively, through a series of voluntary transactions. Thus, if one takes the Principle of Respect for Autonomy seriously, then one should give (at least *prima facie*) support to a commercial system of health care provision and condemn its coercive provision by the State.<sup>21</sup>

## **MARKET BASED HEALTHCARE IS PREFERABLE BECAUSE IT DOES NOT IMPOSE PARTICULAR VALUES ON THE POPULATION AS A WHOLE**

James Stacey Taylor [Associate Professor of Philosophy at The College of New Jersey], "Market-Based Reforms in Health Care Are Both Practical and Morally Sound," *Journal of Law, Medicine, and Ethics*, Special Issue: SYMPOSIUM 1: Conflicts of Interest in the Practice of Medicine, Volume 40, Issue 3, (Fall 2012), pp. 537–546

It has been argued that a market-based system of health care provision is morally superior to its State-based alternative for two reasons: (1) it accords with the utilitarian view that persons should act to secure the greatest happiness for the greatest number, and (2) it would better accord with the Principle of Respect for Autonomy. It has also been noted that not everyone is a utilitarian — and, indeed, utilitarianism might turn out to be false — and in a similar vein, it must be admitted that not everyone accords autonomy high moral value (and, and also in a similar vein, they might be correct not to do so).<sup>28</sup> These admissions lead to the final reason why the market-based provision of health care is morally superior to its State-based alternative: whereas the State-based provision of health care would necessarily involve the coercive imposition of some persons' values upon the citizens as a whole, its market-based alternative would not. Drawing on the above discussion of the second way in which market-based health care would be morally preferable to its State-based alternative, however, it should be noted that insofar as a system of private property would exist only against a general background of coercion, both proposed systems of health care provision would involve the imposition of values. This should come as no surprise, for the imposition of a value-system is intrinsic to any discussion about which social system *should* be imposed. Thus, rather than holding that a market-based system of health care provision would be normatively neutral whereas its State-based rival would not be, it should instead be noted that a State-based system of health care provision would necessarily involve the imposition of a more substantive set of values than would a market-based system. A State-based system of health care would, for example, entail the imposition of the view that certain constituencies of the citizenry should provide for the health care needs of certain others, as well as the imposition of the view of which constituencies should be providers and which recipients. It would also have to address (and hence decide upon) such moral questions as whether to allow or prohibit certain health care-related practices (such as euthanasia or abortion) within those facilities that it claims to be under its jurisdiction, and, if these are to be allowed, whether or not they should be provided under its auspices. It would also have to set standards of professional behavior for the health care providers that it claims to be under its jurisdiction (would, for example, health care professionals be allowed to conscientiously object to the provision of certain forms of treatment, or not?), and impose these in the name of its citizens as a whole. Finally, it would also have to determine precisely what the scope of "health care" is: Would it include preventative treatment, for example? And, if so, what would be included under the rubric of "preventative treatment"? Would it be part of the mandate of the health care system to encourage (or even coerce) persons to exercise, or to eat healthy foods, for example? By contrast, a market-based system of health care would allow persons to make such moral determinations for themselves, restricting their actions only to the extent that this would be required by a system of private property rights. Thus, in a pluralistic world in which many value judgments are contested, a market-based system of health care would provide persons with a greater degree of latitude for the exercise of their moral autonomy than would its State-based alternative.

## **LIBERTY RIGHTS INCOMPATIBLE WITH UHC**

Kelley, David [PhD Princeton University], "Is There a Right to Health Care?" The Atlas Society |. Atlas Society. Web. 21 June 2012.  
<[http://www.atlassociety.org/is\\_health\\_care\\_a\\_right\\_obamacare](http://www.atlassociety.org/is_health_care_a_right_obamacare)>.

Let us consider what liberty rights mean in regard to medical care. If we implemented them fully, patients would be free to choose the type of care they want, and the particular health care providers they want to see, in accordance with their needs and resources. They would be free to choose whether they want health insurance, and if so, in what amounts. Doctors and other providers would be free to offer their services on whatever terms they choose. Prices would be governed not by government fiat, but by competition in a market. Since this is an imaginary state of affairs, no one can predict what mix of private practitioners, HMOs, and other sorts of health plans would emerge. But market forces would tend to ensure that patients have more choices than they do now, that they would act more responsibly than many do at present, and that they would pay actuarially fair prices for health insurance—prices that reflect the actual risks associated with their age, physical condition, and lifestyle. No one would be able to shift his costs onto someone else. In a truly free market, I might add, there would be no tax preference for obtaining health insurance through employers, so most people would probably buy health insurance the way they buy life insurance, auto insurance, or homeowners insurance—directly from insurance companies. They would not have to fear that losing their job, or changing the job, would[n't] mean losing their coverage.

## **RIGHT TO HEALTHCARE IMPOSES OBLIGATION OF PROVISION.**

Kelley, David, [PhD Princeton University], "Is There a Right to Health Care?" The Atlas Society |. Atlas Society. Web. 21 June 2012.  
<[http://www.atlassociety.org/is\\_health\\_care\\_a\\_right\\_obamacare](http://www.atlassociety.org/is_health_care_a_right_obamacare)>.

Health care does not grow on trees or fall from the sky. The assertion of a right to medical care does not guarantee that there is going to be any health care to distribute. The partisans of these rights demand, with air of moral righteousness, that everyone have access to this good. But a demand does not create anything. Health care has to be produced by someone, and paid for by someone. One of the major arguments offered by supporters of a right to health care is that health care is an essential need. What good are our other liberties, they ask, if we cannot get medical treatment for illness? But we must ask, in return: why does need give someone a right? Fifty years ago, people whose kidneys were failing needed dialysis every bit as much as they do today, but there were no dialysis machines. Did they have a right to protection against kidney failure? Was Mother Nature violating their rights by making their kidneys fail without a remedy? It makes no sense to say that need itself confers a right unless someone else has the ability to meet that need. So any "right" to medical care imposes on someone the obligation to provide care to those who cannot provide it for themselves.



**RIGHT TO HEALTH CARE IS INCOMPATIBLE WITH TREATING OTHERS AS ENDS IN THEMSELVES.**

Kelley, David, [PhD Princeton University], "Is There a Right to Health Care?" The Atlas Society |. Atlas Society. Web. 21 June 2012.

<[http://www.atlassociety.org/is\\_health\\_care\\_a\\_right\\_obamacare](http://www.atlassociety.org/is_health_care_a_right_obamacare)>.

If I have such a right, some other person or group has the involuntary, unchosen obligation to provide it. I stress the word "involuntary." A right is an entitlement. If I have a right to medical care, then I am entitled to the time, the effort, the ability, the wealth, of whoever is going to be forced to provide that care. In other words, I own a piece of the taxpayers who subsidize me. I own a piece of the doctors who tend to me. The notion of a right to medical care goes far beyond any notion of charity. A doctor who waives his bill because I am indigent is offering a free gift; he retains his autonomy, and I owe him gratitude. But if I have a right to care, then he is merely giving me my due, and I owe him nothing. If others are forced to serve me in the name of my right to care, then they are being used regardless of their will as a means to my welfare. I am stressing this point because many people do not appreciate that the very concept of welfare rights, including the right to health care, is incompatible with the view of individuals as ends in themselves.

*FREE MARKET GOOD / MORE EFFICIENT*

**THE BEST WAY TO ELIMINATE WASTE IN HEALTHCARE EXPENDITURE IS TO LET PEOPLE CONTROL THEIR OWN HEALTHCARE SPENDING**

Michael F. Cannon [Director of Health Policy Studies, Cato Institute], "Let Customers Control The Money And Market Will Cure Health Care," *Investors Business Daily* (online), July 16, 2009. Accessed Oct. 13, 2012.

Fortunately, Obama has an exit strategy: "If there is a way of getting this done where we're driving down costs and people are getting health insurance at an affordable rate, and have choice of doctor, have flexibility in terms of their plans, and we could do that entirely through the market, I'd be happy to do it that way."

Well, there is a way: Let individuals control their health care dollars, and free them to choose from a wide variety of health plans and providers. If Congress takes those steps, innovation and market competition will make health care better, more affordable and more secure.

Experts suggest that one-third of U.S. health care spending, or about 6% of GDP, is pure waste. The reason is simple: Government controls half of our nation's health care dollars, and lets employers control an additional quarter. And nobody spends other people's money as carefully as they spend their own.

Office of Management and Budget director Peter Orszag told Congress last year: "Imagine what the world would be like if workers (understood) that today it was costing them \$10,000 a year in take-home-pay for their employer-sponsored insurance, and that could be \$7,000 and they could have \$3,000 more in their pockets today if we could relieve these inefficiencies out of the health system." Nothing will increase consumers' understanding like giving them that \$10,000 directly.

## **RETURNING CONTROL OF HEALTH SPENDING TO CONSUMERS REQUIRES EQUALIZING TAX BREAKS AND INSTITUTING A MEDICARE VOUCHER PROGRAM**

Michael F. Cannon [Director of Health Policy Studies, Cato Institute], "Let Customers Control The Money And Market Will Cure Health Care," *Investors Business Daily* (online), July 16, 2009. Accessed Oct. 13, 2012.

Letting consumers control the money requires two steps.

First, Congress should give Medicare enrollees a voucher, let them choose any health plan on the market, and let them keep the savings if they choose an economical plan. Medicare could even give larger vouchers to the poor and sick to ensure they could afford coverage.

Second, Congress needs to give consumers who purchase their own coverage the same tax break as workers with job-based coverage.

Leveling the playing field — whether with tax credits, a standard deduction for health insurance or "large" health savings accounts — would boost purchases of non-job-based coverage, which is critical to cutting the overall number of uninsured.

As important, it would give workers control over the entire \$10,000 Orszag mentioned, for a total effective tax cut of \$532 billion each year. Consumers would eliminate wasteful spending quickly, because they would keep the \$3,000 in savings.

**TO IMPROVE EFFICIENCY IN THE HEALTHCARE SECTOR WE SHOULD ELIMINATE  
BARRIERS TO SELLING MEDICAL SERVICES AND HEALTH INSURANCE ACROSS STATE  
LINES**

Michael F. Cannon [Director of Health Policy Studies, Cato Institute], "Let Customers Control The Money And Market Will Cure Health Care," *Investors Business Daily* (online), July 16, 2009. Accessed Oct. 13, 2012.

We should also eliminate harmful regulation. State health insurance regulations prevent people from purchasing health plans available in other states, and increase premiums by 15%. Similar regulations block competition from more efficient health plans and providers by preventing doctors from taking their licenses from state to state.

Americans deserve the freedom to purchase coverage across state lines. One study estimated that that move alone could cover 17 million uninsured Americans without costing taxpayers a dime. Compare that with Sen. Ted Kennedy's reform bill, which spends \$1 trillion and covers just 16 million uninsured.

Giving clinicians the freedom to practice medicine across state lines would eliminate barriers for retail clinics and economical health plans like Kaiser Permanente, which leads the market in electronic medical records and coordinated care. If we did that, Congress wouldn't need to throw \$30 billion at ineffective pilot programs that try to coordinate care.

## **MARKET-BASED REFORMS DO A BETTER JOB EXPANDING HEALTHCARE COVERAGE**

Michael F. Cannon [Director of Health Policy Studies, Cato Institute], "Let Customers Control The Money And Market Will Cure Health Care," *Investors Business Daily* (online), July 16, 2009. Accessed Oct. 13, 2012.

Critics fear that market-based reforms would leave sick workers unable to obtain coverage. Yet that is already happening as employers drop coverage or eliminate jobs. In reality, these reforms would relieve, if not erase, that problem.

Leveling the playing field will force employers to give sicker workers more than the average \$9,000 or \$10,000 "cash-out," which will help them purchase coverage. When workers buy coverage directly from an insurer, far fewer will end up uninsured when they lose a job.

Finally, large HSAs would provide a tax relief even to those who are too sick to obtain coverage at all.

## **INEFFICIENCY IN THE HEALTHCARE SYSTEM MEANS THAT WE ARE ABLE TO ALLEVIATE LESS SUFFERING**

James Stacey Taylor [Associate Professor of Philosophy at The College of New Jersey], "Market-Based Reforms in Health Care Are Both Practical and Morally Sound," *Journal of Law, Medicine, and Ethics*, Special Issue: SYMPOSIUM 1: Conflicts of Interest in the Practice of Medicine, Volume 40, Issue 3, (Fall 2012), pp. 537–546

Typically, the State provision of health care will (in crude outline) operate on the following lines: the State will secure financial resources through taxing its citizens.<sup>13</sup> Individual persons employed by the State — either politicians or State bureaucrats — will then decide how much of these funds to allocate to health care. (This decision might be a one-off event, or it might be made and re-made on an ongoing basis.) They will then decide how the funds allocated to health care are themselves to be distributed. Given this, there are three reasons why the State will use the funds that it secures inefficiently in comparison to a commercial system of health care provision. And it is important to note that this is not merely an economic point about "wasting taxpayer money." Rather, it is to highlight how citizens are at a disadvantage with State health care: the State will use the funds that it has secured and earmarked for the provision of health care inefficiently compared to a commercial system, which means that for the same amount of money, the State system will (plausibly) alleviate less human suffering and save fewer lives than will its commercial alternative. Thus, since health care resources are finite, using the State to provide any amount of health care will impose upon its citizens a greater amount of suffering and a higher death rate than they would otherwise endure.

**PRIVATE FIRMS ARE MORE ECONOMICALLY EFFICIENT THAN GOVERNMENT AGENCIES BECAUSE THEIR SUCCESS IN THE MARKET IS DEPENDENT ON THEIR EFFICIENCY**

James Stacey Taylor [Associate Professor of Philosophy at The College of New Jersey], "Market-Based Reforms in Health Care Are Both Practical and Morally Sound," *Journal of Law, Medicine, and Ethics*, Special Issue: SYMPOSIUM 1: Conflicts of Interest in the Practice of Medicine, Volume 40, Issue 3, (Fall 2012), pp. 537–546

The first reason why the State provision of health care will use funds less efficiently than its commercial alternative has been well known since at least the days of Adam Smith: commercial organizations have an incentive to use their resources efficiently in a marketplace, but organizations whose success (and hence existence) is not a result of using their resources efficiently will have weak or no external incentive to do so. As a result, it is to be expected that a State provider of health care will provide less health care per dollar of expenditure than would a commercial health care provider since the latter, and not the former, is subject to the sustained and unrelenting pressure of market competition. This in turn drives the provider to use its resources efficiently to provide to consumers the goods and services that it offers. This, of course, is basic economic theory, but is it borne out by the evidence? According to data from the Congressional Research Service, it is not: administrative costs in private insurance companies were 10%, HMOs 12%, and Medicare an impressive 2%.<sup>14</sup> On the face of it, these figures indicate that the State provision of health care is more, not less, efficient than its private counterpart. But this is misleading. The estimates of administrative costs for Medicare exclude many of the actual costs of administering the program, such as the costs of the office buildings and the staff salaries at the Center for Medicare and Medicaid, borrowing expenses incurred by the program, the expenses associated with collecting the taxes to support Medicare, the promotion and marketing costs borne by the program, and the expenses associated with Medicare borne by the Inspector General's office. Worse yet, the apparent differential between private and State administrative costs is exacerbated in the favor of the State by the fact that the State imposes additional costs on the private sector. Such "unfunded mandates" include, for example, the requirement that health care providers inform Medicare of every charge made to a Medicare patient, even if the service at issue is not funded by Medicare, or (if it is), the patient does not request that Medicare be billed.<sup>15</sup> Once these costs have been accounted for, the administrative costs of Medicare and Medicaid are estimated as accounting for 27c for every \$1 of benefits provided, compared with 16c in the private insurance sector.<sup>16</sup>

**THE STATE IS LESS EFFICIENT AT ADMINISTERING HEALTHCARE THAN THE FREE MARKET BECAUSE IT IS SUBJECT TO LOBBYING BY SPECIAL INTEREST GROUPS**

James Stacey Taylor [Associate Professor of Philosophy at The College of New Jersey], "Market-Based Reforms in Health Care Are Both Practical and Morally Sound," *Journal of Law, Medicine, and Ethics*, Special Issue: SYMPOSIUM 1: Conflicts of Interest in the Practice of Medicine, Volume 40, Issue 3, (Fall 2012), pp. 537–546

This economic focus on the incentives that the bureaucrats charged with administering State health care programs will be responding to serves also to illuminate the second reason why it is to be expected that the State provision of health care will be less efficient than its private counterpart: that in a non-market setting, special interest groups can capture resources through lobbying, perverting them away from their efficient allocation. While this phenomenon was implicitly recognized by some of the opponents of early attempts to introduce compulsory health insurance in the United States after the First World War, it was not until 1965 that it received sustained analysis, in Mancur Olson, Jr.'s seminal work *The Logic of Collective Action*.<sup>17</sup> Olson noted that it was rational for persons to lobby politicians directly (rather than through voting) to attempt to have their interests furthered through public policy because voting was an inefficient way of communicating preferences. (When voting for politicians or parties, one votes for a "bundle" of policies, rather than for specific issues.) Such lobbying is, however, difficult for dispersed heterogeneous groups to engage in, both because the costs of organizing for such groups will be high, and even if they decide to try to bear these costs and organize themselves, they will face free-rider problems. By contrast, such lobbying will be easy for homogenous groups to engage in, especially those that are able to avoid free-rider problems through the effective use of some form of enforcement mechanism.



## ALLOCATING RESOURCES BASED ON LOBBYING POWER IS INEFFICIENT

James Stacey Taylor [Associate Professor of Philosophy at The College of New Jersey], "Market-Based Reforms in Health Care Are Both Practical and Morally Sound," *Journal of Law, Medicine, and Ethics*, Special Issue: SYMPOSIUM 1: Conflicts of Interest in the Practice of Medicine, Volume 40, Issue 3, (Fall 2012), pp. 537–546

Both heterogeneous, dispersed groups of persons and homogenous groups of persons will have interests in resources allocated to the State provision of health care. Among the former groups will be those of patients per se, who will be linked by their common status as health care consumers, but divided by age, race, socio-economic class, geography, and types of illness or injury. Among the latter groups will be those who will receive health care resources in their role of health care professionals (including administrators), and those who will receive health care resources as a result of suffering from conditions that place them within a readily-identifiable patient cohort. Given that patients per se would have competing interests concerning the allocation of health care resources (a lung cancer patient in Alabama, for example, would not share the interests of a Parkinson's patient in New York), it is only to be expected that no general lobbying of politicians to spend health care resources in the interests of patients overall will be forthcoming. (Indeed, this is almost a trivial point, for there will be no "general interests of patients" for them to promote.) However, it is to be expected that homogenous groups who could identify both their members *and* police their individual involvement in the lobbying effort (e.g., by forming a fee-based organization, with the benefits of lobbying going primarily or exclusively to its members) would lobby politicians to capture health care resources for themselves. Such lobbying would, if successful, result in State health care resources being transferred to special interest groups even if such a transfer would be a highly inefficient use of them given the goal of improving health. And this is precisely what has happened. In the United Kingdom, for example, "there has been a reduction in industrial action in the NHS [National Health Service] that has coincided with extraordinary increases in funding for the NHS and the allocation of a large proportion of these extra funds to NHS employees," including the provision of "year-on-year above-average pay increases" and an increase in NHS staffing.<sup>18</sup> Similarly, certain diseases and conditions (e.g., breast cancer, Parkinson's disease, autism) affect groups of persons enough of whom will have access to resources to form effective lobbying organizations on their own behalf. Of course, one might object at this point, noting that while the capture of resources by *bureaucrats* is an inefficient use of State health care resources, their transfer to patients for medical use is not. But to do so would be to miss the point of this objection from collective action. The point is not to object to the transfer of health care resources to particular groups. Rather, the point is to object to the inefficient transfer of medical resources to groups on the basis of their political power at the expense of other, more efficient, uses of the same resources. That is, the point of this objection is to show that under the State provision of health care, the dynamics of collective action will lead to inefficient allocations of health care resources. In a free market system, by contrast, such collective actions problems will not arise, and health care resources will be allocated efficiently — where efficiency is here understood as being a proxy term for "less suffering and more lives saved."

## **FUNDING HEALTHCARE THROUGH TAXES IS LESS EFFICIENT BECAUSE PEOPLE ENGAGE IN TAX-AVOIDANT BEHAVIOR**

James Stacey Taylor [Associate Professor of Philosophy at The College of New Jersey], "Market-Based Reforms in Health Care Are Both Practical and Morally Sound," *Journal of Law, Medicine, and Ethics*, Special Issue: SYMPOSIUM 1: Conflicts of Interest in the Practice of Medicine, Volume 40, Issue 3, (Fall 2012), pp. 537–546

The third reason why the State provision of health care will be less efficient than its private counterpart is derived from the fact that the State provision of health care will (typically) be funded through taxation – and taxation imposes deadweight costs on the population subject to it. Imposing taxes on persons — whether in the form of taxing labor through income taxes, or taxing particular products or services — will lead to some of them altering their activities to avoid them. For example, if the State taxes books, then the number of books that will be bought and sold will be fewer, leaving those who would have otherwise bought and sold books worse off. Each dollar raised in taxes to fund a State-provided health care system will incur these deadweight costs. And these can be considerable — the estimates for the deadweight costs of raising one dollar of extra tax revenue in the United States range between 17c and 50c, which (even at the lower estimated level) significantly exceed the costs of collecting premiums in private insurance schemes.<sup>19</sup>

**EVEN IF IT IS TRUE THAT HEALTH CARE SHOULD BE DISTRIBUTED ON THE BASIS OF NEED, IT DOES NOT FOLLOW THAT THE FREE MARKET IS NOT THE BEST MECHANISM TO ACHIEVE THAT**

James Stacey Taylor [Associate Professor of Philosophy at The College of New Jersey], "Market-Based Reforms in Health Care Are Both Practical and Morally Sound," *Journal of Law, Medicine, and Ethics*, Special Issue: SYMPOSIUM 1: Conflicts of Interest in the Practice of Medicine, Volume 40, Issue 3, (Fall 2012), pp. 537–546

Bernard Williams has articulated a view that is similar to that of (1), claiming that (leaving preventative medicine to one side) health care should be distributed to persons on the basis of medical need. However, in a system of commercial health care medical need is only a necessary, and not a sufficient, condition for distributing health care to persons: they will also need to be able to pay for it. And Williams considers this to be morally objectionable.<sup>29</sup> Yet while this line of argument is superficially appealing, it can be dismissed on the grounds that it confuses the reasons that one performs an action with achieving the purpose of that action. That the end of an action A is E does not entail that it is necessary that one's primary motivation for performing A is to bring about E for E to transpire. One might, for example, aim to bring about C (e.g., securing cash for oneself) by performing A, with E's occurrence as a result of A being a necessary condition for C. As such, then, the mere fact that the end of A is E does not entail that for E to transpire one must intend only to bring about E if one performs A. Thus, that the end of medicine is to secure and maintain health does not mean that this end would be undermined were one to practice medicine for reasons other than securing and maintaining health. To put this point more starkly, consider an analogous case involving car mechanics. The purpose of car mechanics is to promote and maintain the good functioning of cars. But while this is true, this does not entail that the only way that this end can be realized is by distributing mechanical work on cars solely on the basis of automotive need. Achieving this end is clearly perfectly compatible with mechanical work on cars being distributed on the basis of both need and the ability to pay.<sup>30</sup>

## ALTRUISM IS NOT A MORAL REQUIREMENT FOR THE PROVISION OF HEALTH CARE

James Stacey Taylor [Associate Professor of Philosophy at The College of New Jersey], "Market-Based Reforms in Health Care Are Both Practical and Morally Sound," *Journal of Law, Medicine, and Ethics*, Special Issue: SYMPOSIUM 1: Conflicts of Interest in the Practice of Medicine, Volume 40, Issue 3, (Fall 2012), pp. 537–546

This response to (1) leads naturally to objection (2): that health care should only be provided altruistically, and so a commercial system of health care provision is immoral. It is important to note just how strong this claim is. It is not the claim that it would be morally better for persons to provide health care altruistically (on the grounds, perhaps, that such altruism towards others is morally laudatory). Rather, it is the claim that unless health care is provided altruistically, its provision is morally wrong. Once this is recognized, it will be seen that this is a very strange claim indeed. First, it is strange because, and contra the views of the proponents of the claim that the commercial provision of health care is necessarily immoral, we do not morally condemn acts solely on the basis of the motives with which they were performed.<sup>31</sup> If Bill and Ben attend the deathbeds of their dying grandmothers (performing externally identical acts that are both *prima facie* right) with Bill doing so out of love for her, and Ben doing so to secure his inheritance, we might fail to praise Ben as we do Bill, but we would not blame him for attending her deathbed. Moreover, (2) is not only at odds with our common-sense ascriptions of rightness and wrongness to acts: it is also at odds with mainstream theoretical ethics. A utilitarian, clearly, would not be concerned with the motives with which a person performed a certain action. But a Kantian would not endorse the concern with motives that underlies the view that health care should only be provided altruistically. To draw from one of Kant's own examples while the act of giving correct change in a commercial transaction only has moral worth if it is done out of respect for the moral law, we would not blame someone who performed this act only out of a concern for his commercial reputation.<sup>32</sup> Finally, if health care should only be provided altruistically, it would appear that those who labor to provide it (health care professionals, laboratory technicians, the entrepreneurs who develop medical devices and pharmaceuticals, and others) are doing something morally wrong unless their services are being provided freely — or perhaps (and more modestly) unless they are compensated for their services at the lowest levels of compensation that are available to them outside the health care field. But even the more modest version of this implication of the view that health care should be provided altruistically is decidedly odd, for it implies that no health care provider should be paid more than, for example, an undocumented migrant agricultural worker. Thus, insofar as (2) is at odds both with common sense morality and theoretical ethics, and, if taken to its logical conclusion would lead to absurd results, we have good reason to reject it.

**BECAUSE MARKETS ARE MORE ECONOMICALLY EFFICIENT, UTILITARIANS WILL  
SUPPORT FREE-MARKET BASED HEALTHCARE**

James Stacey Taylor [Associate Professor of Philosophy at The College of New Jersey], "Market-Based Reforms in Health Care Are Both Practical and Morally Sound," *Journal of Law, Medicine, and Ethics*, Special Issue: SYMPOSIUM 1: Conflicts of Interest in the Practice of Medicine, Volume 40, Issue 3, (Fall 2012), pp. 537–546

If one is a utilitarian, then the moral advantages that the market-based approach holds over its State-based rival will already be clear. Since the former will use resources more efficiently than the latter, and hence will be able to secure a greater amount of health care (and hence, plausibly, human well-being) for the same amount of resources, one who is concerned with securing "the greatest happiness for the greatest number" should support the commercial, rather than the State, provision of health care.

#### **UNIVERSAL HEALTHCARE IS LESS EFFICIENT.**

Emma Roberts [B.A., University of Windsor; Emma Roberts has been a professional writer since 2000. Her work has appeared in "NOW Magazine," "HOUR Magazine" and the "Globe and Mail." She has also worked with Columbia University.] WHAT IS BAD ABOUT UNIVERSAL HEALTH CARE? June 14, 2011. LiveStrong. <<http://www.livestrong.com/article/273041-what-is-bad-about-universal-health-care/>>

Some countries with universal health care struggle to sustain efficiency. Canada and Australia ranked lowest, according to the Commonwealth Wealth Fund study, in accessibility of physician appointments and wait times for basic medical services, as well as specialist care, tests, and elective surgery. Other efficiency issues noted by the study included Canada's propensity for misplacing medical records and tests.

## **PUBLIC OPTION DESTROYS THE INSURANCE INDUSTRY.**

Stossel, John, Andrew Sullivan, and Andrew Kirell. "Canadian Health Care: The End of Innovation?" ABC News. ABC News Network, 26 June 2009. Web. 02 July 2012.  
<<http://abcnews.go.com/2020/Stossel/story?id=7938095>>.

Canada and Great Britain have what's called a "single-payer" health care system: the government pays for everyone's health care using tax revenue. It's true that Obama says he doesn't want a health care system exactly like that. Instead, he says he wants to set up a public insurance program run by the government that will compete alongside private insurance plans. However, critics warn that a plan like this won't allow private insurers to compete on a level playing field. They say the government will keep costs down for their public plan by setting payment rates for doctors below the market level, the same way that Medicare does now. "What will happen in the long run is that private insurers will not be able to compete with the government on price," Pipes predicts, "so they will leave the market."

**US HEALTHCARE SYSTEMS WOULD BE SOLVED WITH MORE PRO-MARKET REFORM,  
NOT MORE GOVERNMENT CONTROL.**

Tanner, Michael D. "The Grass Is Not Always Greener: A Look at National Health Care Systems Around the World." The Cato Institute. March 18, 2008.

<http://www.cato.org/publications/policy-analysis/grass-is-not-always-greener-look-national-health-care-systems-around-world>

The U.S. health care system clearly has problems. Costs are rising and are distributed in a way that makes it difficult for some people to afford the care they want or need. Moreover, although the number of uninsured Americans is often exaggerated, far too many Americans go without health insurance. And while the U.S. provides the world's highest quality health care, that quality is uneven, and too often Americans don't receive the standard of care that they should. But the experiences of other countries with national health care systems show that the answer to these problems lies with more pro-market reform, not more government control.



## **INCREASING HEALTHCARE COMPETITION LOWERS COSTS.**

Tanner, Michael D. "5 Ways to Solve Health Care." June 9, 2012.  
<http://www.cato.org/publications/commentary/5-ways-solve-health-care>

Putting purchasing power in the hands of consumers is only half of market-based reform. We also need to increase competition in the insurance market. Today, for example, people can't purchase health insurance across state lines. This effectively creates near monopolies in many states with only a handful of insurance companies controlling the vast majority of a state's market. For example, in New York, just two insurers, GHI and Empire Blue Cross, represent 47% of the market. In New Jersey, a single insurer, Horizon Blue Cross and Blue Shield, controls 43% of the market. And in Connecticut, Wellpoint holds an astounding 55%. Nationwide, there are more than 1,300 insurance companies, including some 500 nonprofit, cooperative and mutual insurers. Consumers should be able to buy insurance from any of them, forcing insurers to compete on price and service. And because different states have very different regulations and mandates, costs can vary widely depending on where you live. These regulations are a major reason why New York and New Jersey have some of the nation's highest insurance premiums. But with consumers able to escape those costly regulations by purchasing insurance elsewhere, states would be forced to evaluate whether their regulations offered true value or simply reflected the influence of special interests.

*OVERUTILIZATION AND COSTS*

**GOVERNMENT HEALTHCARE SUBSIDIES CAUSE OVER-UTILIZATION OF HEALTH SERVICES; CASH DISTRIBUTIONS ARE THE PREFERABLE WAY TO HELP THE POOR**

Jeffrey A. Miron [Senior Lecturer in Economics, Harvard University; Senior Fellow, Cato Institute], "Public Option: Treatment Worse Than the Disease," *Cato.org*, Oct. 29, 2009. Accessed 10/13/2012.

The underlying presumption behind this legislation is that the government health insurance should be expanded to cover the uninsured.

This presumption is wrong. Government should not subsidize health insurance — for the uninsured, the poor, the elderly or anyone else — or regulate health insurance markets. Here's why.

Subsidizing health insurance means that patients and doctors are insulated from the costs of health care, so they utilize too much — often in the form of unnecessary tests or medical procedures whose value hasn't been proven. This excess demand, along with technological progress, means rapidly growing deficits, so governments limit reimbursements to health providers or ration care. This kills innovation and creates its own inequities. The taxes necessary to fund subsidies are a drag on economic growth.

The reason the Obama administration and congressional Democrats are seeking to cover the uninsured is that health insurance is expensive. Without government support, many people could not afford health insurance. The conventional wisdom is that government should therefore subsidize health insurance for those who cannot afford it.

This confuses two issues: whether government should help the poor, and how government should help the poor. If society wants everyone to have health insurance, the obvious approach is to give the poor enough money so that individuals can purchase on their own. Just because people want government to help the poor doesn't require it to pay for specific kinds of goods. If some people do not purchase insurance and then become ill, they would have to rely on private charity.

## OVERUTILIZATION OF HEALTHCARE IS A MAJOR DRIVER OF HEALTHCARE COSTS IN THE UNITED STATES

Ezekiel J. Emanuel [MD, PhD; Department of Bioethics, The Clinical Center, National Institutes of Health] and Victory R. Fuchs [Prof. Department of Economics, Stanford University], "The Perfect Storm of Overutilization," *JAMA*, Vol 299, No. 23 (June 18, 2008)

The most important contributor to the high cost of US health care, however, is overutilization. Overutilization can take 2 forms: higher volumes, such as more office visits, hospitalizations, tests, procedures, and prescriptions than are appropriate or more costly specialists, tests, procedures, and prescriptions than are appropriate.

It is more costly care, rather than high volume, that accounts for higher expenditures in the United States. The volume of services is not extreme. A hospitalization rate of 121 per 1000 US patients is higher than that of Japan (106) but considerably lower than the rate in Switzerland (157), Norway (173), and France (268) and lower than the Organisation for Economic Co-operation and Development (OECD) average (163) (Table).<sup>3,4</sup> The US hospitalization rate is 21st of 30 OECD countries. Similarly, US patients have 3.8 physician visits annually per capita, fewer than the OECD average of 6.8.<sup>3,4,6</sup>

In contrast with volume, in which the United States is not the leader, there are almost 3 times as many magnetic resonance imaging scanners in the United States as the OECD average, higher only in Japan.<sup>3,4</sup> US patients receive considerably more cardiac revascularization procedures (579 per 100 000 population)—coronary artery bypass grafts, angioplasties, and stents—45% more than patients in Norway, the country with the next highest number (Table).<sup>3,4</sup> The United States has the fourth highest per capita consumption of pharmaceuticals. 6 US patients utilize many more "new drugs"—those on the market 5 years or fewer—than patients in other countries.<sup>6</sup> For instance, ezetimibe, which decreases low-density lipoprotein cholesterol level and was approved in October 2002, is not recommended by major guidelines<sup>7</sup> as first-line therapy. Nevertheless, the use of ezetimibe in the United States is about 5 times higher than it is in Canada, constituting more than 15% of prescriptions for lipid-lowering agents.<sup>8</sup> Greater use of new, more expensive pharmaceuticals, as well as higher prices both for older and newer drugs, helps explain why the United States spent \$752 per capita (2005) on drugs, whereas France, with the next highest expenditure, spent \$559 and Japan just \$425.<sup>3,4,6</sup>

### **COSTS OF UHC ARE UNSUSTAINABLE.**

Emma Roberts [B.A., University of Windsor; Emma Roberts has been a professional writer since 2000. Her work has appeared in "NOW Magazine," "HOUR Magazine" and the "Globe and Mail." She has also worked with Columbia University.] WHAT IS BAD ABOUT UNIVERSAL HEALTH CARE? June 14, 2011. LiveStrong. <<http://www.livestrong.com/article/273041-what-is-bad-about-universal-health-care/>>

Some countries with universal health care struggle to sustain efficiency. Canada and Australia ranked lowest, according to the Commonwealth Wealth Fund study, in accessibility of physician appointments and wait times for basic medical services, as well as specialist care, tests, and elective surgery. Other efficiency issues noted by the study included Canada's propensity for misplacing medical records and tests.

### **UHC IS PLAGUED BY RISING COSTS.**

Tanner, Michael D. "The Grass Is Not Always Greener: A Look at National Health Care Systems Around the World." The Cato Institute. March 18, 2008.

<http://www.cato.org/publications/policy-analysis/grass-is-not-always-greener-look-national-health-care-systems-around-world>

In most cases, national health care systems have successfully expanded insurance coverage to the vast majority, if not quite all, of the population. But they have not solved the universal and seemingly intractable problem of rising health care costs. In many cases, attempts to control costs through governmental fiat have led to problems with access to care, either delays in receiving care or outright rationing. In wrestling with this dilemma, many countries are loosening government controls and injecting market mechanisms, particularly cost sharing by patients, market pricing of goods and services, and increased competition among insurers and providers. As Pat Cox, former president of the European Parliament, put it in a report to the European Commission, "We should start to explore the power of the market as a way of achieving much better value for money."

**COSTS ARE INCREASING AND MANY ARE UNCOVERED, EVEN WITH OBAMACARE.**

Tanner, Michael D. "5 Ways to Solve Health Care." June 9, 2012.  
<http://www.cato.org/publications/commentary/5-ways-solve-health-care>

Most importantly, regardless of the Court's decision, the problems with our health-care system are not going away. The US health-care system has much to recommend it. We produce most of the research, innovation and technology that improves health care throughout the world. Americans have more choice of physicians and treatments than patients in other countries. And if you are sick, your chances of survival are far better in this country than elsewhere. But one only has to open their latest insurance bill to see that the cost of health care is still going up. On average, health insurance in New York now costs nearly \$6,000 for an individual and \$16,000 for a family, more in New York City. Premiums are expected to rise by 8.2% this year, increasing faster than wages. At the same time, too many Americans remain uninsured. Although the number of uninsured is often exaggerated by critics of the system, approximately 50 million Americans could be without health insurance at any given time, 2.7 million of them in New York. Even if ObamaCare is fully implemented, as many as 23 million Americans would still lack health insurance by 2020.

## **MEDICARE WILL BANKRUPT THE US.**

Tanner, Michael D. "5 Ways to Solve Health Care." June 9, 2012.  
<http://www.cato.org/publications/commentary/5-ways-solve-health-care>

While much of the debate over health-care reform focuses on private health insurance, it is important to remember that half of all health-care spending is done by the federal government. And the 800-pound gorilla of the American health-care system is Medicare. Medicare was essentially modeled after a 1965 Blue Cross insurance plan, and has not been substantially updated since [1965]. It pays doctors on the basis of how much treatment they provide, not on whether that treatment is effective[ness]. In fact, if the treatment makes you sicker, and you have to receive additional treatment, the doctor gets paid more. At the same time, physicians are reimbursed at such low rates per procedure that some costs are shifted onto privately insured workers, while physicians are beginning to drop out of the system. Worse, because of changing demographics, and because most seniors receive far more in Medicare benefits than they pay in Medicare taxes and premiums, the program is threatening to bankrupt the country. Even if one accepts the most optimistic estimates for Medicare's finances, the program faces future shortfalls of more than \$56 trillion. Other estimates suggest that the program's unfunded liabilities could actually reach as much as \$125 trillion.

*SCARCITY, RATIONING, AND QUALITY OF CARE*

**THE SUPPOSED RIGHT TO A DECENT MINIMUM OF HEALTH IS MANIFESTLY IMPLAUSIBLE**

Allen E. Buchanan [Prof. of Philosophy, Duke University], "The Right to a Decent Minimum of Health Care," *Philosophy & Public Affairs*, Vol. 13, No. 1 (Winter, 1984), pp. 55-78

Sometimes the notion of a decent minimum is applied not to health care but to health itself, the claim being that everyone is entitled to some minimal level, or welfare floor, of health. I shall not explore this variant of the decent minimum idea because I think its implausibility is obvious. The main difficulty is that assuring any significant level of health for all is simply not within the domain of social control. If the alleged right is understood instead as the right to everything which can be done to achieve some significant level of health for all, then the claim that there is such a right becomes implausible simply because it ignores the fact that in circumstances of scarcity the total social expenditure on health must be constrained by the need to allocate resources for other goods.



**DANIELS' ARGUMENT FOR A DECENT MINIMUM OF HEALTHCARE FAILS TO ADEQUATELY ACCOUNT FOR THE PROBLEM OF SCARCE RESOURCES**

Allen E. Buchanan [Prof. of Philosophy, Duke University], "The Right to a Decent Minimum of Health Care," *Philosophy & Public Affairs*, Vol. 13, No. 1 (Winter, 1984), pp. 55-78

A third and somewhat surprising feature of Daniels's position, and one which many will view as objectionable, is that it appears that principle D does not guarantee a universal right to a decent minimum of health care. For D is silent on how we are to make difficult and basic allocation decisions: it does not tell us whether we are to devote all resources to narrowing the distance between the opportunity ranges of the worst off and the normal opportunity range or to divide resources among all who fall short of the normal opportunity range. Indeed nothing in D even acknowledges that there is a problem of scarcity. Whether or not D will require some minimal set of health-care services for all will depend upon which additional principles we adopt to cope with priority problems in the face of scarcity. If our first priority is to narrow the gap between the worst off and the normal opportunity range, then, depending on how badly off the worst off are and depending upon the total amount of resources available, there may be nothing left for even minimal services for those who do not fall within the worst off class. As in the case of Utilitarianism, whether there is a universal right to a decent minimum will depend upon the facts about the society in question. But in Daniels's scheme it will also depend upon what additional principles of distributive justice are used to supplement the principle of equality of opportunity when the commitment to such a strong principle collides with the realities of scarcity. If, on the other hand, the commitment to raising the opportunity range of the worst off is to be limited by a principle stating that everyone has a right to some set of services even if there are others who are farther from the normal opportunity range, then, unless this universal right claim can be nonarbitrarily specified and supported, it appears that we have again ushered in the idea of a decent minimum. And contrary to what Daniels says, his principle of equality of opportunity is a supplement, rather than a replacement for it.

### **1.7 MILLION CANADIANS HAVE NO ACCESS TO COVERAGE.**

Stossel, John, Andrew Sullivan, and Andrew Kirell. "Canadian Health Care: The End of Innovation?" ABC News. ABC News Network, 26 June 2009. Web. 02 July 2012.  
<<http://abcnews.go.com/2020/Stossel/story?id=7938095>>.

"The only way they can get costs down under a government-run system is to control the amount of money that is spent on health care," says Sally Pipes of the Pacific Research Institute, who was born in Canada, and is wary about government taking the reins of health care in the U.S. "We are going to have denied care, lack of access to the latest technology, and long waiting lists, just like people do in Canada and Great Britain," she warns.

In those countries, the government pays for all health care, and bureaucrats put limits on spending in order to control costs. They determine how much doctors can be reimbursed and put caps on the amount of money that can be spent on treatments. The result of all this cost-cutting? People wait for care. A national shortage of general practitioners means that 1.7 million Canadians don't have access to a regular doctor to go to for routine care. In England, shortages of dentists have caused hundreds of people to wait in line just for an appointment. The queues can be so long that some people have resorted to pulling out their own rotting teeth, using vodka and pliers as tools. One British hospital even tried to save money by not changing bed sheets. Instead of washing them, a British newspaper reported that the staff was encouraged to simply turn the sheets over. At any given time in Great Britain, there are over half a million people waiting to get into a hospital for treatments.

But Obama has said he doesn't want a government takeover of health care. "When you hear the naysayers claim that I'm trying to bring about government-run health care," he told the American Medical Association last week, "know this -- they're not telling the truth."

### **CANADA HAS HUGE WAIT TIMES AND SHORTAGE OF SPACE.**

Stossel, John, Andrew Sullivan, and Andrew Kirell. "Canadian Health Care: The End of Innovation?" ABC News. ABC News Network, 26 June 2009. Web. 02 July 2012.  
<<http://abcnews.go.com/2020/Stossel/story?id=7938095>>.

"People line up for care. Some of them die. That's what happens," Dr. David Gratzner says of Canada's health care system. Gratzner, a Canadian doctor, thought Canada's government health care system was great -- until he started treating patients. "The more time I spent in the Canadian system, the more I came across people waiting for radiation therapy. Waiting for the knee replacement so they could finally walk up to the second floor of their house," he explained. "You want to see your neurologist because of your stress headache? No problem! You just have to wait six months," he continued. "You want an MRI? No problem! Free as the air. You've just got to wait six months." Many ER doctors in Canada agree that the system is broken. They say hospitals face a consistent shortage of bed space, and patients often have to wait. While people in America also wait in emergency rooms, the wait is different in Canada. When patients go to the ER for treatment and are found to be sick enough to enter the hospital, they have to wait in the emergency room for an average of 19 hours before they can be given a hospital bed. We can't send these patients to other hospitals that have capacity because there is no other hospital in the area that has capacity," said Dr. Eric Letovsky, an ER doctor from Ontario. "Every other emergency department in the country is just as packed as we are."

**THOUSANDS ABANDON GOVERNMENT HEALTHCARE AND COME TO THE US FOR THE BEST TREATMENT.**

Stossel, John, Andrew Sullivan, and Andrew Kirell. "Canadian Health Care: The End of Innovation?" ABC News. ABC News Network, 26 June 2009. Web. 02 July 2012.  
<<http://abcnews.go.com/2020/Stossel/story?id=7938095>>.

It's true that America's partly-private, profit-driven system is expensive and sometimes wasteful, but that pursuit of profit has allowed our health care system to offer rapid delivery, great doctors, and incredible lifesaving discoveries. This is the country of medical innovation. This is where people come when they need treatment," said Gratzner. Thousands come from countries with government-run health care to take advantage of the advanced care in the United States. The famous Spanish tenor Jose Carreras didn't get treated for cancer in Spain -- he went to Seattle. King Hussein of Jordan came to America for treatment. So did Italian Prime Minister Silvio Berlusconi and South African Archbishop Desmond Tutu. Literally, we're surrounded by medical miracles. Death by cardiovascular disease has dropped by two-thirds in the last 50 years," said Gratzner. "You've got to pay a price for that type of advancement,"

*INNOVATION*

**SINGLE PAYER KILLS INNOVATION OF CLINICAL REIMBURSEMENT.**

Minkoff, Neil. "Medicare's Payment System Harms Medical Innovation." Forbes. Forbes Magazine, 22 May 2012. Web. 02 July 2012.  
<<http://www.forbes.com/sites/aroy/2012/05/22/medicares-payment-system-harms-medical-innovation/>>

Medicare's payment system hinders innovation in health care. How? Government is harmful to medical innovation by setting so much of the reimbursement process. By being, by far, the largest payer of healthcare claims in America, the Medicare fee schedule drives the market for all other private payers. In essence, this sets a floor for clinical reimbursement. Hospitals then set budgets based on expected revenue, not based on the cost of providing specific services. Patient experience, convenience and quality of care do not effect, or at least significantly effect, clinical reimbursement in the standard, traditional fee-for-service Medicare program. There is therefore no incentive to find ways to create new value in the system. By law, a physician or hospital cannot charge premium pricing for a Medicare-reimbursed service or procedure. I first notice this while treating patient maybe 15 years ago. A first- or second-year physician, I was treating a patient with a serious lung impairment caused by a blood clot in his pulmonary artery. I was transferring this patient from a poorly run suburban hospital, soon to close, to arguably the world's expert on these types of clots at the Brigham and Women's, which is consistently rated as one of the nation's ten finest facilities. Medicare was paying both physicians the same fee and both hospitals the same fee.

**SINGLE PAYER CREATES A SENSE OF “GOOD ENOUGH” – KILLS INCENTIVE FOR INNOVATION.**

Minkoff, Neil. "Medicare's Payment System Harms Medical Innovation." Forbes. Forbes Magazine, 22 May 2012. Web. 02 July 2012.  
<<http://www.forbes.com/sites/aroy/2012/05/22/medicares-payment-system-harms-medical-innovation/>>

This is wrong. This encourages a sense in the market of care that is “good enough.” Nowhere do Medicare providers have any incentive, outside of their integrity and drive, to develop, improve and excel. Only recently has Medicare paid any attention to outpatient quality of care through the Physician Quality Reporting System and, even then, caps payment of a quality bonus to 0.5% of the previous year’s Medicare payments to the provider. This means it costs more to collect the data to report to Medicare than one can earn for collecting it. Furthermore, the setting of the Medicare fee schedule exempts most of medicine from basic rules of supply-and-demand. Here is an example: over the past five years, Medicare reimbursement for cataract surgery rose from around \$900 to about \$1,050, a 17% increase, despite a growing volume of procedures as the population ages and what would otherwise be an incentive to lower prices to attract this new volume. Conversely, elective visual corrective surgery dropped over a similar time span from \$2,100 per eye to \$1,700, a 20% increase. The pressure of the market forced providers to innovate better, more cost-effective ways to do the procedure while maintaining a positive, safe patient experience. These providers have tremendous incentive to measure, report and improve quality-of-care, patient experience and cost.

**SINGLE PAYER DOESN'T ACCOUNT FOR INDIVIDUAL EXPERIENCE – KILLS INNOVATION.**

Minkoff, Neil. "Medicare's Payment System Harms Medical Innovation." Forbes. Forbes Magazine, 22 May 2012. Web. 02 July 2012.  
<http://www.forbes.com/sites/aroy/2012/05/22/medicares-payment-system-harms-medical-innovation/>

Payment not based on individual experience may account for another example. Since laparoscopic gallbladder removal became the standard of care, the risk of tearing the bile duct which was the most common serious complication, has plummeted. However, the risk of a common, minor complication, a dropped stone lost in the abdominal cavity, has remained unchanged for over 15 years. There is not enough incentive under current reimbursement to improve a mild issue. In no other industry where service providers compete on price and quality would this lack of innovation be tolerated. An irrational, one-size-fits-all fee schedule that does not reward quality, patient experience and clinical expertise traps the American public in a medical system where one is rewarded only for doing things... but not for doing them well.

**US LEADS MEDICAL INNOVATION IN THE SQUO – PRODUCT OF PUBLIC AND PRIVATE SECTOR COALITION.**

Partnership Practice, The Battele Technology. "Gone Tomorrow?" American Medical Innovation. The Council for American Medical Innovation, 10 June 2010. Web. 2 July 2012.  
<[http://www.americanmedicalinnovation.org/sites/default/files/Gone\\_Tomorrow.pdf](http://www.americanmedicalinnovation.org/sites/default/files/Gone_Tomorrow.pdf)>

Over the past 30 years, the unique, complementary investments made and actions taken by the public and private sectors helped the United States become the leader in medical innovation worldwide. Today medical innovation remains a defining feature for the United States in the global economy. But, as this report reflects, many believe that the U.S. leadership position is tenuous. While 'here today,' it could be 'gone tomorrow.' The keys to our past success in medical innovation are that while the public sector made significant, sustained investments in basic life sciences research and in talent generation, the private sector invested in research and development (R&D) of breakthrough medical technologies . . . spurring job creation and economic growth through new medical products and services that have produced to a significant dividend of health gains for society overall. We also made public policy decisions that recognized the importance of intellectual property (IP), facilitated technology transfer, created science-based product review and approval, and maintained and created incentives to attract investments that resulted in the founding and growth of new companies and the development of breakthrough medical technologies.



**MEDICAL INNOVATION FACES MULTIPLE CHALLENGES – ONLY PUBLIC-PRIVATE COLLABORATION CAN SOLVE.**

Partnership Practice, The Battelle Technology. "Gone Tomorrow?" American Medical Innovation. The Council for American Medical Innovation, 10 June 2010. Web. 2 July 2012.  
<[http://www.americanmedicalinnovation.org/sites/default/files/Gone\\_Tomorrow.pdf](http://www.americanmedicalinnovation.org/sites/default/files/Gone_Tomorrow.pdf)>

This highly interrelated, synergistic blend of public-private partnership strength and resources is not found in any other technology sector. Indeed, the dependencies between academia-led basic science largely funded by the public sector and private industry-led product development are quite striking. One study found that 31 percent of new products and 11 percent of new processes in the biomedical field could not have been developed, without substantial delay, in the absence of academic research. American medical innovation now stands at a crossroads. Our leadership in medical innovation and the health benefits and economic growth that accrue because of it are at risk. What has changed is: Biomedical science has become more complex and demanding, requiring more involved technology development efforts, including more complex clinical trials. Regulatory review and approval processes are not keeping pace with scientific advances and are no longer as predictable or consistent. Early-stage financing and private investment for R&D are harder to access because of the changing risks and rewards in advancing medical innovation. Talent pipeline supporting medical innovation is at risk. Meeting these challenges will depend on strengthening and leveraging the public-private collaboration that helped the United States become the world leader in medical innovation. In the past, the public and private sectors, otherwise operating independently, have come together through a new architecture to address a crisis facing the nation. One need only think of defining efforts to bolster national defense, to bring talent and focus to the nation's competencies during the emergence of the semiconductor age, or to advance our impressive national labs to realize the power of this partnership in America. Many of the experts interviewed suggested that nothing less than a discrete new mission-focused venture where public and private expertise and investment can come together to spur translation and early development is required today to sustain the nation's vital medical innovation enterprise.

## **WELL-BALANCED APPROACH KEY TO MAINTAINING US LEADERSHIP IN MEDICAL INNOVATION.**

Partnership Practice, The Battele Technology. "Gone Tomorrow?" American Medical Innovation. The Council for American Medical Innovation, 10 June 2010. Web. 2 July 2012.  
<[http://www.americanmedicalinnovation.org/sites/default/files/Gone\\_Tomorrow.pdf](http://www.americanmedicalinnovation.org/sites/default/files/Gone_Tomorrow.pdf)>

Despite the diversity of stakeholders involved in medical innovation, there is wide agreement among them that we cannot take our success and ongoing competitiveness in medical innovation for granted and we face some considerable challenges. Over the past 30 years, the United States has become the global leader in biomedical development because of its world-class medical innovation ecosystem. The experts interviewed point out that, in the 1970s, the United States was not yet a world leader in medical innovation. Instead, Europe led in the medical innovation industry, with Germany, Switzerland, and the United Kingdom as the dominant players. The United States earned its global leadership—as measured by industry development, inventions, and scientific publications—based on a well-balanced approach involving key roles for both the public and private sectors. The hallmarks of our medical innovation ecosystem include the following: Sustained public investment in medical research Enlightened public policies supporting technology transfer and IP protection Advanced venture financing at all stages of firm development A robust market for new treatments and technologies A tax and regulatory climate that provided a path for private enterprise to advance new product development. Today, global leadership in medical innovation and resulting biomedical development is “ours to lose.” And we seem to be doing just that. While many other nations are strategically investing to support medical innovation as an economic growth strategy, we have allowed our ecosystem for medical innovation to decline. Though the leadership gap is narrowing, the United States stills leads and, with proactive policy changes, can secure continued leadership and fuel job growth and economic development for the United States.

**PUBLIC/PRIVATE PARTNERSHIP KEY TO SOLVE FDA INCONSISTENCY IN REGULATORY REVIEW.**

Partnership Practice, The Battele Technology. "Gone Tomorrow?" American Medical Innovation. The Council for American Medical Innovation, 10 June 2010. Web. 2 July 2012.  
<[http://www.americanmedicalinnovation.org/sites/default/files/Gone\\_Tomorrow.pdf](http://www.americanmedicalinnovation.org/sites/default/files/Gone_Tomorrow.pdf)>

Challenge: Lack of consistency and predictability in U.S. Food and Drug Administration (FDA) regulatory review and uncertainties in reimbursement and new standards under healthcare reform. One significant challenge of our own doing is the failure to keep up the scientific, objective, and predictable basis of our regulatory review and approval processes. In the midst of the explosion of scientific knowledge and improvements, we have allowed our regulatory system to fall behind in its scientific skills and tools and instead become mired in processes that are unable to predictably balance the need for safety as well as patient benefits. The cost of this is huge. The lack of certainty and predictability in the review and approval process heightens risks of failure, raises the costs of development, makes the struggle to raise capital more difficult, and ultimately denies patients timely access to innovative treatments. While the FDA is working to address this issue, in part with its proposed Initiative for Advancing Regulatory Science, the resources available are very limited and a broader public-private partnership is needed to bring forward the needed expertise from government, patient advocates, the research community, and industry.

*MORAL HAZARD*

**PROVIDING HEALTH INSURANCE TO PEOPLE WITH PRE-EXISTING CONDITIONS  
INCENTIVIZES UNHEALTHY BEHAVIOR**

Jeffrey A. Miron [Senior Lecturer in Economics, Harvard University; Senior Fellow, Cato Institute], "Public Option: Treatment Worse Than the Disease," *Cato.org*, Oct. 29, 2009. Accessed 10/13/2012.

The other possible objection to the cash transfer approach holds that, if left unregulated, private health insurers would deny coverage based on pre-existing conditions. Thus, some people might get no health insurance at all.

This outcome is unlikely, however, assuming health insurance is unregulated. In that case, insurers would set higher premiums for the unhealthy, but they would cover anyone willing to pay a sufficiently high price. Thus, the question is whether society should compensate those who face higher prices because of their health status?

The answer is no. Advocates for such compensation would suggest that it is basic fairness for society to insure people against the bad luck of being born with lousy genes. Many differences in health status, however, arise from behavior: heart disease from overeating, lung cancer from smoking, and cirrhosis from drinking, to name a few. If society compensates everyone for differences in their health status, it is often rewarding unhealthy behavior, perhaps even encouraging it.

## **UNIVERSAL HEALTHCARE IS UNFAIR TO HEALTH-CONSCIOUS CITIZENS.**

Emma Roberts [B.A., University of Windsor; Emma Roberts has been a professional writer since 2000. Her work has appeared in "NOW Magazine," "HOUR Magazine" and the "Globe and Mail." She has also worked with Columbia University.] WHAT IS BAD ABOUT UNIVERSAL HEALTH CARE? June 14, 2011. LiveStrong. <<http://www.livestrong.com/article/273041-what-is-bad-about-universal-health-care/>>

Advocates of universal health care believe it should be a right for all citizens. However, since all citizens are not created equal, health wise, universal health care could end up being unfair to health-conscious citizens. Smokers, for example, receive the same treatment under universal health care, even though their conditions are self-induced, as non-smokers. Smoking-related illnesses like emphysema and lung cancer place an enormous drain on the system, and are mostly preventable. A similar argument can be made for those who are overweight or heavy drinkers. In a universal health care system, people do not have to take responsibility for the health consequences of bad lifestyle choices. Everyone gets covered, and everyone shares the cost.

*A2 RIGHT TO HEALTHCARE*

**TO SAY THAT PEOPLE OUGHT TO HAVE A DECENT MINIMUM OF HEALTHCARE IS NOT SUFFICIENT TO DEMONSTRATE THAT THERE IS A *RIGHT* TO SUCH HEALTHCARE**

Allen E. Buchanan [Prof. of Philosophy, Duke University], "The Right to a Decent Minimum of Health Care," *Philosophy & Public Affairs*, Vol. 13, No. 1 (Winter, 1984), pp. 55-78

I think it is fair to say that many who confidently assume there is a (universal) right to a decent minimum of health care have failed to appreciate the significance of the first feature of our sketch of the concept of a right. It is crucial to observe that the claim that there is a right to a decent minimum is much stronger than the claim that everyone ought to have access to such a minimum, or that if they did it would be a good thing, or that any society which is capable, without great sacrifice, of providing a decent minimum but fails to do so is deeply morally defective. None of the latter assertions implies the existence of a right, if this is understood as a moral entitlement which ought to be established by the coercive power of the state if necessary. This simple point finds expression in traditional ethical theories and in our ordinary moral discourse, for a distinction is made between both 'ought'-judgments that express claims of right and those that express imperatives founded on moral virtues other than justice. In particular, distinction is drawn between imperatives of justice and imperatives of charity or beneficence or generosity, the assumption usually being that only the former may be enforced.

**BENEFICENCE MAY BE A VERY STRONG MORAL INTEREST, BUT THAT DOES NOT MAKE IT A RIGHT; THIS IS PROBLEMATIC FOR RAWLSIAN THEORY**

Allen E. Buchanan [Prof. of Philosophy, Duke University], "The Right to a Decent Minimum of Health Care," *Philosophy & Public Affairs*, Vol. 13, No. 1 (Winter, 1984), pp. 55-78

Further, the difference between 'we ought to provide X to A' and 'A has a right to X' is not a difference between different degrees of strength or constancy in our moral convictions. To the morally virtuous person the imperatives of charity may be as urgent as those of justice. This point has troubling implications for attempts to establish right-claims by the use of what Rawls calls the method of reflective equilibrium. According to this method, we are to appeal to our particular considered moral judgments as provisional data to be accounted for and organized by a smaller set of more general moral principles. The difficulty is that we may be much surer that someone ought not to lack a certain form of health care than we are about whether the ground of this judgment is a principle that structures our sense of justice or our sense of charity or beneficence or generosity. And even if we can show what makes health care, or certain kinds of health care, morally important, this in itself will not show that there is a right to health care, unless the appropriate connection with principles of justice can be made.

## UTILITARIANISM DOES NOT JUSTIFY A UNIVERSAL RIGHT TO A BASIC MINIMUM OF HEALTHCARE

Allen E. Buchanan [Prof. of Philosophy, Duke University], "The Right to a Decent Minimum of Health Care," *Philosophy & Public Affairs*, Vol. 13, No. 1 (Winter, 1984), pp. 55-78

*Utilitarian Arguments.* The chief difficulty with utilitarian arguments is that they are not capable of providing a secure foundation for a right to a decent minimum for everyone. Consider, for example, the class, of Down's syndrome newborns. These retarded individuals, who often suffer from various physical defects as well, require a large expenditure of social resources over a lifetime. And relative to these costs the contribution these individuals make to social utility is not large, at least as far as we must work with a conception of contribution that is in some way quantifiable. If this is so, then Utilitarianism will justify excluding these infants from even the most minimal health care provided to others as a matter of right.

It is important to see that individuals in this class are capable of various enjoyments and would greatly benefit from the services from which they are excluded. Thus Utilitarianism may require that, even for the most basic services, what is guaranteed for one individual may not be available to another, even though their needs are equal and both would benefit greatly from the service.

My purpose in developing this example is not to show conclusively that there are no circumstances or no likely circumstances in which Utilitarianism would support a (derivative) universal right to a decent minimum of health care. Instead I have only shown that, granted certain plausible factual assumptions which may in fact be satisfied in our society at this time, there is good reason to doubt that Utilitarianism provides a secure foundation for such a right.



## **RAWLSIAN THEORY IS INSUFFICIENT TO JUSTIFY A RIGHT TO BASIC MINIMUM HEALTHCARE**

Allen E. Buchanan [Prof. of Philosophy, Duke University], "The Right to a Decent Minimum of Health Care," *Philosophy & Public Affairs*, Vol. 13, No. 1 (Winter, 1984), pp. 55-78

Let us suppose that health care is either itself a primary good covered by the difference principle or that health care may be purchased with income or some other form of wealth which is included under the difference principle. In the former case, depending upon various empirical conditions, it might turn out that the best way to satisfy the difference principle is to establish a state-enforced right to health care. But whether maximizing the prospects of the worst off will require such a right and what the content of the right will be depends upon what weight is to be assigned to health care relative to other primary goods included under the difference principle. Similarly, a weighting must also be assigned if we are to determine whether the share of wealth one receives under the difference principle would be sufficient both for health-care needs and for other ends. Until we have some solution to the weighting problem, Rawls's theory can shed only limited light upon the question of priority relations between health care and other goods and among various forms of health care.

It is important to see that the informational constraints imposed by Rawls's "veil of ignorance" preclude a solution to the problem of weighting health care against other primary goods because the answer will depend upon facts about the particular conditions of the society in which the notions in question are to be applied. At best Rawls's hypothetical contractors would choose a kind of placeholder for a principle establishing a right to a decent minimum of health care, on the assumption that the content of the right can only be filled out at later stages of agreement in the light of specific information about their particular society.

However, nothing in Rawls's conception of rational decision suggests that once the relevant, concrete information is available, rational persons will agree on a single assignment of weights to the primary goods. It follows that Rawls's theory does not itself supply content for the notion of a right to a decent minimum of health care: instead, at best, it lays down a very abstract structure within which this content will be worked out through the democratic political processes specified by the list of equal basic liberties. Given this, Rawls's theory advances us very little beyond the broad intuitive consensus that there is a universal right to a decent minimum of health care.

### **DANIELS' ARGUMENT FROM EQUALITY OF OPPORTUNITY CREATES IMPOSSIBLY STRONG OBLIGATIONS**

Allen E. Buchanan [Prof. of Philosophy, Duke University], "The Right to a Decent Minimum of Health Care," *Philosophy & Public Affairs*, Vol. 13, No. 1 (Winter, 1984), pp. 55-78

The first difficulty is the definition of "normal opportunity range." The phrase "the array of life-plans reasonable to pursue" is ambiguous. For whom must a life-plan be reasonable to pursue if it is to be included in the normal opportunity range? If to be included a plan must be reasonable for everyone to pursue, regardless of his or her physical abilities, skills, and talents, then the list will be so modest that it is doubtful that it could provide content for a substantive universal right to health care of the sort Daniels wants. If, on the other hand, inclusion in the normal opportunity range requires only that the plan be such that it is reasonable for someone or other to pursue it, then D becomes astonishingly strong, since it will include life-plans requiring exceptional talents and rare characteristics.

On this strong interpretation, Daniels's principle of equality of opportunity is vulnerable to the same objection that leads to the rejection of the strong equal access principle. Granted the gap between most individuals' actual opportunity ranges and the array of plans it is reasonable for some individuals to pursue, and granted the almost limitless possibility for technology and other services which can help narrow the gap, a conscientious commitment to D would create an enormous drain on resources. To say that everyone has a right to whatever arrangements are necessary to insure that it is reasonable for him to aspire to become a neurosurgeon, a first-class logician, an accomplished pianist, or the spouse of a movie star seems excessive to say the least.

**US CONSTITUTION GUARANTEES BASIC LIBERTY RIGHTS, BUT NOT RIGHT TO HEALTH CARE.**

Kelley, David, [PhD Princeton University], "Is There a Right to Health Care?" The Atlas Society |. Atlas Society. Web. 21 June 2012.  
<[http://www.atlassociety.org/is\\_health\\_care\\_a\\_right\\_obamacare](http://www.atlassociety.org/is_health_care_a_right_obamacare)>.

It is also worth noting that the Supreme Court has never recognized a constitutional basis for any welfare right, including the right to medical care. The Court recognizes that the concept of rights embodied in our legal system is the concept of liberty rights. Welfare rights are a product of later movements to expand the role of government beyond the original conception of its role. In our constitutional system, there is no requirement that the federal government provide health care. Health care entitlements, unlike fundamental rights like freedom of speech, have to be invented by legislators.

*A2 DISTRIBUTIVE JUSTICE*

**THE GUARANTEE TO A NORMAL RANGE OF OPPORTUNITY DEPENDS ON THE RANGE OF HEALTH SERVICES ALREADY AVAILABLE, MAKING THE PRINCIPLE BOTH CIRCULAR AND OVERLY CONSERVATIVE**

Allen E. Buchanan [Prof. of Philosophy, Duke University], "The Right to a Decent Minimum of Health Care," *Philosophy & Public Affairs*, Vol. 13, No. 1 (Winter, 1984), pp. 55-78

A second difficulty is that if we eschew the strong interpretation, the attempt to derive a right to health care from the right to enjoy the normal opportunity range for one's own society may involve a sort of circularity which has unfortunately conservative implications for health-care policy. The array of life-plans which all (or most or many) people in a given society can reasonably pursue or that constitute a tolerable or normal or adequate life in that society will be determined in part by the availability and quality of health care in that society. In other words, the normal opportunity range is itself in part a social artifact. Thus in a society with very poor health-care services the normal opportunity range is correspondingly narrow, even if the society were in fact affluent enough to afford a wider range of services which would allow a wider normal opportunity range. Consequently, a principle which requires only that resources be allocated so as to assure that everyone attains the normal opportunity range would be inadequate in situations in which the normal opportunity range was unacceptably narrow due to a failure to allocate sufficient resources for health care. This suggests that Daniels's principle requiring equal opportunity must be supplemented with a principle requiring maximization of the opportunity range, or at least that the opportunity range is to be maximized up to some limit. After all, the importance of health care on Daniels's account is that it facilitates opportunity, and anyone who is concerned with opportunity rather than with equality for its own sake will desire arrangements which require more than mere equality of opportunity if opportunities are few but can be expanded.

*A2: PATIENT PROTECTION AND AFFORDABLE CARE ACT*

**THE INDIVIDUAL MANDATE LACKS CONSTITUTIONAL DUE PROCESS PROTECTIONS**

Steven J. Willisand [Prof. of Law, University of Florida College of Law] and Nakku Chung [Member of the Florida Bar], "No Healthcare Penalty? No Problem: No Due Process," 38 Am. J.L. & Med. 516 (2012)

The Internal Revenue Service (IRS) has the power to assess and to collect the penalty for failing to have adequate health insurance. 25 Unlike other taxes and penalties, the lack-of-health-insurance penalty has virtually no procedural protections for individuals subjected to it.<sup>26</sup>

The IRS must notify the individual of its assessment and intent to collect before it may collect the amount assessed. It need provide neither a formal nor an informal hearing, no opportunity to respond, no opportunity to litigate the issue in a court, nor even a significant waiting period prior to collection.<sup>27</sup> Instead, if the IRS believes an individual lacks health insurance and thus owes the Penalty, it must notify him or her of such and then it may collect the amount due.<sup>28</sup> An individual only has the right to seek a refund administratively after payment.<sup>29</sup> If that fails, the individual may then sue for a refund in either federal district court or the Claims Court.<sup>30</sup> The individual will have the burden of proof.<sup>31</sup> Arguably, this amounts to the civil equivalent to a criminal presumption of guilt. 32

**INDIVIDUALS SUBJECT TO THE TAX FOR NOT BUYING HEALTH INSURANCE DO NOT  
HAVE ADEQUATE OPPORTUNITIES FOR APPELLATE REVIEW**

Steven J. Willisand [Prof. of Law, University of Florida College of Law] and Nakku Chung [Member of the Florida Bar], "No Healthcare Penalty? No Problem: No Due Process," 38 Am. J.L. & Med. 516 (2012)

If the IRS believes an individual has violated the Mandate, it must notify him or her of the Penalty and demand that he or she pay it." 5 It can then collect the amount alleged to be due."16

That is it. No audit. No opportunity to respond. No need for actual notice. No administrative hearing. No court hearing. No court judgment. Nothing but perfunctory notice and demand followed by collection. Prior to collection of a tax, taxpayers since 1998 have had a judicially reviewable right to a fair hearing, even if the hearing itself is merely administrative. Although taxpayers do not always have a statutory right to judicial review on the merits, they at least have the right to judicial review of the fairness of the administrative review." 7 For the section 5000A healthcare Penalty, however, no such right exists." Even if the Treasury or IRS adopts protest or appeal procedures for the Penalty, they cannot be judicially reviewable: the Tax Court lacks jurisdiction to hear such matters!9 and neither the Treasury nor the IRS has the authority to grant such jurisdiction, which only Congress may grant.120 District courts would be barred by the Anti-Injunction Act from hearing such matters prior to collection.'21

## **THE CLAIM THAT OBAMACARE ALLOWS YOU TO KEEP YOUR OWN HEALTH INSURANCE IS FALSE**

Michael D. Tanner [Senior Fellow, Cato Institute], "Perils of Obamacare: The Three Big Lies," *The New York Post*, July 20 2009. Accessed Oct. 13, 2012. URL = <<http://www.cato.org/publications/commentary/perils-obamacare-three-big-lies>>

"If you like your current health-care plan, you can keep it." Even White House spokesmen have said that Obama's oft-repeated pledge that you can keep your current insurance isn't meant to be taken literally. The reality is that millions of Americans — perhaps most Americans — will be forced to change insurance plans.

First, the president supports an individual mandate — a requirement that every American buy health insurance. And not just any insurance but insurance that includes all the benefits government thinks you should have. That insurance could be more expensive or include benefits that people don't want or are morally opposed to, such as abortion services.

And that doesn't just affect those without insurance today. The bills now before Congress say that while you won't be immediately forced to switch from your current insurance to a government-specified plan, you'll have to switch to satisfy the government's requirements if you lose your current insurance or want to change plans.

Plus, the president supports the creation of a government insurance program that would compete with private insurance. But because this ultimately would be subsidized by American taxpayers, the government plan could keep its premiums artificially low or offer extra benefit.

In the end, millions of Americans would be forced out of the insurance they have today and into the government plan. Businesses, in particular, would have every incentive to dump their workers into the public plan. The actuarial firm the Lewin Group estimates that as many as 118.5 million people, roughly two-thirds of those with insurance today, would be shifted from private to public coverage.

## **OBAMACARE MEANS THAT INDIVIDUALS WILL PAY MORE IN TAXES AND HEALTH CARE COSTS**

Michael D. Tanner [Senior Fellow, Cato Institute], "Perils of Obamacare: The Three Big Lies," *The New York Post*, July 20 2009. Accessed Oct. 13, 2012. URL = <<http://www.cato.org/publications/commentary/perils-obamacare-three-big-lies>>

"You will pay less." The Congressional Budget Office has made it clear that the reform plans now being debated will increase overall health-care costs, yet President Obama on Friday repeatedly said that his reform would reduce costs and save Americans money.

But no matter how many times he says it, the truth is you will pay more — much more — both in higher taxes and in higher premiums.

The final health-care bill is expected to cost more than \$1 trillion over the next 10 years. That means much higher taxes, and not just for the wealthy.

If one totals up all the new taxes in the House Democratic health-reform bill — the income surtax, the penalties on businesses and individuals that fail to buy into the government health plan, as well as other fees and taxes — the cost to US taxpayers will top \$800 billion. New York City will face marginal tax rates as high as 57 percent.

At a time of rising unemployment and economic stagnation, that is like throwing an anchor to a drowning man.

In addition, the new insurance regulations expected to be part of the final bill are likely to drive up insurance premiums. And, if the new government-run plan under-reimburses doctors and hospitals — as Medicare and Medicaid do — providers would be forced to recoup that lost income by shifting their costs to private insurance, driving up premiums. A study by the Council for Affordable Health Insurance estimates that the president's proposals could increase premiums by 75 to 95 percent.



## **OBAMACARE WILL HARM THE QUALITY OF HEALTH CARE**

Michael D. Tanner [Senior Fellow, Cato Institute], "Perils of Obamacare: The Three Big Lies," *The New York Post*, July 20 2009. Accessed Oct. 13, 2012. URL = <<http://www.cato.org/publications/commentary/perils-obamacare-three-big-lies>>

"Quality will improve." Anyone who thinks a government takeover of the health-care system will improve quality of care has only to look at the health-care programs the government already runs: The Veterans Administration is overwhelmed with problems, Medicaid is notorious for providing poor quality at a high cost — and Medicare has huge gaps in coverage.

Worse, however, on Friday, Obama endorsed the creation of a government board with the power to dictate how your doctor practices medicine and all but endorsed the rationing prevalent in nationalized health-care systems around the world.

*IMPLEMENTATION PROBLEMS AND FEDERALISM*

**UNIVERSAL HEALTH CARE WILL FAIL UNLESS TIED TO A PROPERLY DESIGNED DELIVERY SYSTEM—AN ISSUE ON WHICH THERE IS RADICAL DISAGREEMENT IN THE UNITED STATES.**

Lawrence D. Brown [Professor of Health Policy and Management, Mailman School of Public Health, Columbia University]. "Comparing Health Systems in Four Countries: Lessons for the United States," American Journal of Public Health, January 2003, Vol 93, No. 1.

The United States, the esteemed source of much of the theory and practice of the services integration other nations seek to emulate, may be ahead of the international curve but faces integrative challenges of its own. Both here and abroad, proponents of reform sometimes divide over whether the achievement of universal coverage is a necessary and sufficient policy objective, over whether to insist that such coverage be encased in a properly designed delivery system. Americans must decide how far to tie reform to managed care, the driver of US-style integration, and increasingly an 800-lb gorilla politically. Will the new system seek to redeem a fee-for-service system, follow Medicare's dubious lead into some variant of choice between a fee-for-service system and managed care, or assume that managed care will be mainstream and fee-for-service payment an exception? Beyond decisions about how far to push managed care lie others on what to do about managed competition, an issue that has vexed US health policy since the 1970s. Is integration—in this case the proliferation of managed care organizations—a natural institutional receipt for better efficiency and quality? Or do these objectives presuppose competition among integrated entities? Can this competition stay loosely managed, as now, or would universal coverage trigger anew the many disputes about managed competition that sunk the Clinton plan a few years ago? Ironically, other nations are better equipped to address integration incrementally than the United States is: here it invites a host of radical questions.

## FEDERALISM DA LINK

Lawrence D. Brown [Professor of Health Policy and Management, Mailman School of Public Health, Columbia University]. "Comparing Health Systems in Four Countries: Lessons for the United States," *American Journal of Public Health*, January 2003, Vol 93, No. 1.

The 4 countries all recognize that strong, continuing leadership by the central government is the sine qua non of affordable universal coverage. Great Britain is, of course, the home of "socialized medicine." Efforts by France's famously powerful state to reform the health care system have multiplied in the last 2 decades, especially since the Juppe reforms of 1996. Germany's central government is a "supervisor, enabler, facilitator, monitor,"<sup>4</sup> and purveyor of national standards for the health system. Canada's constitution reserves health duties for the provinces, but the central government uses its financial leverage to enforce on them 5 straightforward principles that protect solidarity and equity for Canadian citizens. None of the 4 countries, however, supposes that health policy can be run entirely from London, Paris, Berlin, or Ottawa. Germany and Canada are federal systems and, as Altenstetter<sup>4</sup> and Deber<sup>1</sup> explain, a mix of constitutional, political, and informal rules and norms ensure that states and provinces participate extensively in making and running health policies that affect them. With such consultation comes conflict and delay, but federalism and universal coverage are eminently compatible.

Great Britain and France have created new regional and community bodies—the Primary Care Trusts in the former and regional hospital councils and public health conferences in the latter, for instance—that encourage deliberation and coordination closer to the proverbial grass roots. All 4 acknowledge that decentralization and devolution are goals worth pursuing, but they also understand that workable decentralization presupposes effective centralization of policy authority.

## **AN INDIVIDUAL INSURANCE MANDATE IS NOT REQUIRED TO SOLVE THE PROBLEM OF ADVERSE SELECTION**

Jeffrey A. Miron [Senior Lecturer in Economics, Harvard University; Senior Fellow, Cato Institute], "Should Government Subsidize Health Insurance?," *Cato.org*, Mar. 25, 2011. Accessed 10/13/2012.

The standard justification for subsidizing health insurance holds that private markets will not supply "fair" insurance due to a phenomenon known as adverse selection. This perspective assumes that insurers cannot tell which applicants are healthy, so they must charge the same premium to everyone. Then, however, only the unhealthy apply, and insurers go broke.

Government can in principle fix this problem by mandating that everyone buy insurance, preventing any "adverse selection" of applicants. But this mandate must include subsidies for low-income households, who otherwise cannot afford insurance.

This argument for government insurance is standard, but it suffers a key flaw: insurers can readily determine applicant health via physical exams and medical histories. So, private insurers will offer health insurance to all applicants, with one key caveat: they will charge higher premiums to those in poor health. This is precisely what most people fear about a free market for insurance.

## **NO SINGLE CONCEPT OF UHC – FOREIGN SYSTEMS NOT NECESSARILY APPLICABLE TO THE US**

Tanner, Michael D. "The Grass Is Not Always Greener: A Look at National Health Care Systems Around the World." The Cato Institute. March 18, 2008.  
<http://www.cato.org/publications/policy-analysis/grass-is-not-always-greener-look-national-health-care-systems-around-world>

Of course, there is no single model for national health care systems in other countries. Indeed, the differences from country to country are so great that the terms "national health care" or "universal coverage" can be misleading—as if one collective model shows how other countries deal with health care and health insurance. Each country's system is the product of its unique conditions, history, politics, and national character. Those systems range from the managed competition approach of the Netherlands and Switzerland to the more rigid single-payer systems of Great Britain, Canada and Norway, with many variations in between. Some countries have a true single-payer system, prohibiting private insurance and even restricting the ability of patients to spend their own money on health care. Others are multipayer systems, with private competing insurers and varying degrees of government subsidy and regulation. Some countries base their systems around employment, while others have completely divorced work from insurance. Some require consumers to share a significant portion of health care costs through either high deductibles or high copayments. Others subsidize virtually first-dollar coverage. Some allow unfettered choice of physicians. Others allow a choice of primary care physicians but require referrals for specialists. Still others restrict even the choice of primary care doctors. In fact, about the only system one cannot find is the type of system described by Michael Moore, Physicians for a National Health Program, and other national health care advocates—a system that provides unlimited care with no premiums, deductibles, or copayments, from the physician of one's choice. For example, in SiCKO, Moore lambastes American insurers for denying coverage for rare and experimental treatments.<sup>327</sup> And, during the New Hampshire primary, John Edwards ran television advertisements highlighting the tragic death of a teenage girl whose liver transplant was rejected by her father's insurer. These stories play effectively on the emotions and drive a desire for change. Yet one searches in vain for a national health care system anywhere that regularly pays for experimental and untested procedures. Likewise, advocates for national health care tap into the anger many patients (and doctors) feel [anger] for the gatekeepers and prior approval required under American managed care. But many if not most foreign systems require similar gatekeepers. Moreover, copayments and other forms of cost sharing are commonplace. It is also important to realize that no country's system would translate directly to the United States. Americans are unlikely to accept the rationing or restrictions on care and technology that many countries use to control costs. Nor are U.S. physicians [aren't] likely to accept a cut in income to the levels seen in countries like France or Germany. The politics, economics, and national cultures of other countries often vary significantly from those of the United States. Their citizens are far more likely to have faith in government actions and to be suspicious of free markets. And polling suggests that citizens of many countries put social solidarity and equality ahead of quality and choice when it comes to health policy.<sup>329</sup> American attitudes are quite different. As pollster Bill McInturff notes, "Never, in my years of work, have I found someone who said, 'I will reduce the quality of the health care I get, so that all Americans can get something.'"

## **UHC DOES NOT GUARANTEE UNIVERSAL COVERAGE**

Tanner, Michael D. "The Grass Is Not Always Greener: A Look at National Health Care Systems Around the World." The Cato Institute. March 18, 2008.  
<http://www.cato.org/publications/policy-analysis/grass-is-not-always-greener-look-national-health-care-systems-around-world>

Universal health insurance does not mean universal access to health care. In practice, many countries promise universal coverage but ration care or have extremely long waiting lists for treatment. Nor does a national health care system necessarily mean universal coverage. Some countries with ostensibly universal systems actually fall far short of universal coverage, and most leave at least a small remnant (1–2 percent of the population) uncovered. Although this is certainly wider coverage than the United States provides, it shows the difficulty of achieving either truly universal coverage or universal access to care.

## **COUNTRIES ARE MOVING AWAY FROM GOVERNMENT-RUN SYSTEMS.**

Tanner, Michael D. "The Grass Is Not Always Greener: A Look at National Health Care Systems Around the World." The Cato Institute. March 18, 2008.  
<http://www.cato.org/publications/policy-analysis/grass-is-not-always-greener-look-national-health-care-systems-around-world>

Although no country with universal coverage is contemplating abandoning a universal system, the broad and growing trend in countries with national health care systems is to move away from centralized government control and introduce more market-oriented features. As Richard Saltman and Josep Figueras of the World Health Organization put it, "The presumption of public primacy is being reassessed."<sup>337</sup> Alan Jacobs of Harvard points out that despite significant differences in goals, content, and strategies, European nations are generally converging toward market practices in health care. Thus, even as Americans debate adopting a government-run system, countries with those systems are debating how to make their systems look more like that of the United States. Looking at other countries and their experiences, then, can provide guidance to Americans as we debate how to reform our health care system. National health care is not a monolithic idea, nor is it as disastrous as U.S. critics sometimes portray. Some national health care systems do some things well. Yet, those systems do have serious problems.

*PERSONAL INSURANCE ALT*

**EMPLOYER BASED INSURANCE IS ILLOGICAL AND AROSE OUT OF UNIQUE CONDITIONS.**

Tanner, Michael D. "5 Ways to Solve Health Care." June 9, 2012.  
<http://www.cato.org/publications/commentary/5-ways-solve-health-care>

Nothing would do more to fix our health-care system than moving away from a system dominated by employer-provided health insurance and instead making health insurance personal and portable, controlled by the individual rather than government or an employer. There is, after all, no logical reason for an individual to receive health insurance through their job. We don't receive most other types of insurance — auto, homeowners, life — in that way. Employer-based health insurance is an anomaly that grew out of unique historical circumstances during World War II. Despite the widespread entry of women into the labor force during the war, the shift of men from private employment to the military created a labor shortage. At the same time, wage controls prevented employers from competing for available workers by raising salaries. In an effort to circumvent the regulations and compete for available workers, employers began to offer non-wage benefits, including health insurance. In 1953, the IRS ruled that employer-provided health insurance was not part of wage compensation for tax purposes. This means that if a worker is paid \$40,000, but their employer also provides an insurance policy worth \$16,000, the worker pays taxes on just the \$40,000 in wages. If, however, instead of providing insurance, the employer gave the worker a \$16,000 raise — allowing the worker to purchase his or her own insurance — the worker would have to pay taxes on \$66,000, a tax hike of as much as \$2,400. This puts workers who buy their own insurance at a significant disadvantage compared to those who receive insurance through work.



**EMPLOYER BASED INSURANCES CAUSES OVER-CONSUMPTION AND MAKES POST-EMPLOYMENT INSURANCE DIFFICULT TO ACQUIRE.**

Tanner, Michael D. "5 Ways to Solve Health Care." June 9, 2012.  
<http://www.cato.org/publications/commentary/5-ways-solve-health-care>

Employment-based insurance distorts our health-care system in several ways. Most significantly, it hides much of the true cost of health care to consumers, thereby encouraging over consumption. If workers believe someone else is paying for their health care, they have less incentive to be frugal consumers. People naturally eat more at the all-you-can-eat buffet, than if they have to pay a la carte. Basing insurance on employment also means that if you lose your job, you are likely to end up uninsured. Worse, once you've lost insurance, it can be hard to get new coverage, especially if you have a pre-existing condition.

## **MAKING INSURANCE PERSONAL SOLVES, INCREASES COVERAGE.**

Tanner, Michael D. "5 Ways to Solve Health Care." June 9, 2012.  
<http://www.cato.org/publications/commentary/5-ways-solve-health-care>

Changing from employer to individual insurance requires changing the tax treatment of health insurance. Employer-provided insurance should be treated the same as other compensation for tax purposes: that is, as taxable income. To offset the increased tax, workers should receive a standard deduction, a tax credit, or expanded Health Savings Accounts (HSAs), regardless of whether they receive insurance through their job or purchase it on their own. As a result of this shift in tax policy, employers would gradually substitute higher wages for insurance, allowing the worker to shop for the insurance policy that most closely matched his or her needs. That insurance would be more likely to be true insurance, protecting the worker against catastrophic risk, while requiring out-of-pocket payment for routine, low-dollar costs, and it would belong to the worker, not the employer, meaning that workers would be able to take it from job to job and would not lose it if they became unemployed. And, since workers could maintain continuous coverage, the issue of preexisting conditions becomes far less of a problem. Putting workers in charge of their own insurance would significantly reduce the cost of insurance. A study by Stephen Parente of the University of Minnesota suggests that making this change would increase the number of people with health insurance by 21-27 million, nearly as many as projected under ObamaCare.

*HELP THE POOR ALT*

## **GOVERNMENT SHOULD SUBSIDIZE HEALTH INSURANCE FOR THE POOR AND NOBODY ELSE**

Jeffrey A. Miron [Senior Lecturer in Economics, Harvard University; Senior Fellow, Cato Institute], "Should Government Subsidize Health Insurance?," *Cato.org*, Mar. 25, 2011. Accessed 10/13/2012.

The real issue for health insurance, therefore, is whether policy should protect people against the differences in economic circumstance implied by their differences in health.

This kind of redistribution strikes many people as compassionate. And, behind a veil-of-ignorance — before knowing one's future health — most people would trade some consumption for protection against the possibility of a bad health outcome. Since markets do not seem to offer such insurance, government provision can make everyone better off.

Yet this view does not justify government health insurance for all. Any attempt in this direction would be costly, since everyone would demand unlimited health care. Full or substantial government insurance trades one problem — the high cost of private insurance for some people — for a different problem: an inefficient and expensive health care system.

The natural way to balance these concerns is to subsidize health insurance for the poor, but for no one else. Roughly, this mean eliminating Medicare, Obamacare, and the tax-subsidy for employer-provided insurance, but retaining a (scaled down) version of Medicaid.

This approach insures everyone against the worst case scenario in which poor health makes it impossible to earn income. This approach also means that even among the non-poor, some people will pay higher health insurance premiums than others.